MEDICARE PART B PREMIUM FOR 1988

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

SEPTEMBER 30, 1987

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MEDICARE PART B PREMIUM FOR 1988

WEDNESDAY, SEPTEMBER 30, 1987

House of Representatives,
Committee on Ways and Means,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room 1100 Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the committee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 17, 1987

PRESS RELEASE #17
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-3625

THE HONORABLE DAN ROSTENKOWSKI (D., ILL.), CHAIRMAN, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE MEDICARE PART B PREMIUM FOR 1988

The Honorable Dan Rostenkowski (D., Ill.,), Chairman of the Committee on Ways and Means, U.S. House of Representatives, today announced that the Full Committee will hold a hearing on the Medicare Part B premium for 1988. The hearing will be held on Wednesday, September 30, 1987, beginning at 9:30 a.m., in the Committee's main hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Rostenkowski stated, "I am shocked by reports that the Department of Health and Human Services may increase the Medicare Part B premium by over 38 percent, from $17.90 to $24.80 a month next year. This increase is unprecedented during a time of low inflation.

"The elderly already pay for half of their health care out-of-pocket. Now, they will have to pay almost $300 a year for Part B premiums. This will be particularly difficult for the 50 percent of the elderly with incomes of less than $10,000.

"It is imperative for the Department to clearly explain to the Committee why such a significant increase in the Part B premium is justified. The main problem appears to be continued rapid growth in Part B payments, particularly payments to physicians.

"The sharp increase in premiums will force Congress to give serious consideration to reforming Medicare's system for paying physicians."

The purpose of the hearing will be to review the data and analysis used by the Administration to support their proposed increase, to better understand the factors contributing to escalating Part B premiums, and to review the potential effect of the premium increase on Medicare beneficiaries.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND

Medicare Part B is a voluntary insurance program for the elderly and disabled, which is financed partly by premiums, and covers a variety of health care services including physician services, outpatient hospital care, laboratory testing, and renal dialysis. Benefit payments are expected to total $24 billion in Fiscal Year 1988. Physician services account for 72 percent of the total.

Premiums are calculated annually at a level sufficient to generate 25 percent of projected program costs. According to press reports, the Part B premium for 1988 will be $24.80 a month, compared with $8.20 a month 10 years ago -- a 200-percent increase.

This increase has been primarily driven by increases in Part B outlays which have been growing at an average annual rate of 17 percent a year over the past 10 years. Preliminary data indicate that outlays will increase by 22 percent during 1987.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS

For those who wish to file written comments for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, October 23, 1987, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Committee office, 1102 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

COMMITTEE ON WAYS AND MEANS FORMATTING REQUIREMENTS FOR PRINTING OF HEARING STATEMENTS, WRITTEN COMMENTS AND EXHIBITS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman **Rostenkowski**. The committee will come to order.

Today the administration will announce a 39 percent increase in the Medicare part B premium. This means a monthly premium increase of $6.90, from $17.90 to $24.80 a month.

In comparison, monthly Social Security checks will increase by an estimated 4.3 percent or an average of $21 per month. So, much of the annual cost-of-living increases for retirees will be spent on higher Medicare premiums.

The impact will be particularly hard on those elderly, 15 million in all, with incomes of less than $10,000 a year.

I am shocked by this increase. But I understand that the administration is acting in good faith and is attempting to comply fairly with current law which requires that premium revenues equal one-quarter of part B program costs.

The real problem is that part B expenses continue to grow rapidly. Over the past 5 years, outlays have been increasing at an average rate of 16 percent a year. This year, outlays surged ahead by an astonishing 22 percent.

This is in sharp contrast to Medicare part A. Prospective payment appears to be controlling hospital costs.

Developing a new approach to control part B costs while protecting quality will be difficult. However, controlling part B costs is a priority matter that we must begin to tackle immediately if Medicare part B is to remain affordable for the elderly and for taxpayers.

In the meantime, next year's premium increase will raise out-of-pocket expenditures for the elderly and the disabled, 10 percent of whom already pay over $1,500 a year in Medicare coinsurance and deductibles.

The House of Representatives has passed Medicare catastrophic health legislation that will reduce out of pocket medical costs for millions of elderly and disabled and provide all Medicare beneficiaries with the security of knowing that they no longer face bankruptcy from large hospital and physician bills.

Given the critical need for this legislation, and the tremendous amount of work done this year, I hope the Senate will soon report a Medicare catastrophic health bill. I am confident that once the Senate approves a bill, we will be able to come up with a conference agreement that the President will sign.

Today's hearing is on the 39-percent increase in the part B premium that becomes effective January 1. From invited witnesses, we hope to obtain information explaining why this increase is necessary and what the implications of such an unprecedented increase might be.

Also, I hope we might obtain information that will help the committee develop measures that will prevent such large part B premium increases in the future.

Mr. Duncan.

Mr. **Duncan**. Thank you, Mr. Chairman. I want to thank you also for calling this timely hearing.

I share your concern about the 39-percent increase in the 1987 Medicare part B premium which is being announced today. As you indicated, the administration is responding to the laws we have given them to operate under.

This increase will place a particular burden on many of this Nation's most economically vulnerable citizens, the elderly and the disabled. The increase also reflects dramatic growth in overall Medicare part B expenditures.

It is troublesome to see such program expansions on the spending side of the ledger when the Ways and Means Committee has deficit reduction as its highest priority.

The point of this hearing, however, should not be to wring our hands and look for villains. No individuals or groups have their hands in the till. Neither physicians nor beneficiaries should be blamed.

Instead, I think, Mr. Chairman, the committee should view the increase as an opportunity to get us into the important business of reforming Medicare part B payment. We learned in 1983, by adopting the Medicare prospective payment system for hospitals, that the providers and the payers can work together to put into place payment methods which encourage efficiency and reduce program outlays.

We have no ready reform, such as hospital DRGs for part B. Clearly, the DRGs themselves will not work on the physician side of the Medicare ledger.

So, Mr. Chairman, we must begin today the task of examining the causes for the growth in the part B outlays and seek the guidance of the physician community and other experts. We need to develop payment methods for part B which will not undermine quality of or access to care, but help us constrain program costs.

I look forward to the hearings. You have a good list of witnesses, Mr. Chairman, and I thank you very much.

Chairman **Rostenkowski**. Mr. Stark.

Mr. **Stark**. Thank you, Mr. Chairman.

I am pleased that these hearings were called today because it is our responsibility to ensure that health care remains affordable for the elderly and for the taxpayers.

The 39-percent proposed increase in the Medicare part B premium presents a real challenge to this committee. We must ask all parties to this, the administration and the providers of services under part B, questions that will clearly indicate whether these increases are justified or not. The main problem appears to be the increasing of payments to physicians and other providers.

Over the past 5 years, part B outlays have nearly doubled from $15 billion in 1982 to $30 billion in 1987. The 5-year average growth rate is 15 percent a year. This year outlays are ahead by 22 percent and this has exceeded the cost of any other inflation indicator for any of those past years.

These facts are striking. The question is where is the money going and are we getting our money's worth?

Two-thirds of the increase in part B spending is going to physicians. Over the past 5 years, total payments to physicians have been increasing at an average rate of 14 percent a year.

More than half, 55 percent of the increase in total payments, is due to increased volume of services, office visits, tests, x rays, and surgery, to beneficiaries; 30 percent of the increase is due to increased prices, and only 15 percent is due to the increases in the number of elderly in the program.

Despite all the complaints we hear, the physicians are doing very well. From 1980 to 1985, Medicare payments per physician increased at an average rate of 4.4 percent a year, after adjusting for inflation. This year, payments per physician will increase by 12 percent above inflation. In 1986, the average physician earned $113,000 in income after all expenses, including malpractice insurance had been subtracted. This is a 10-percent increase compared with a 1.1-percent increase in the Consumer Price Index and the 1-, 2-, or 3-percent increase that our beneficiaries will receive in their Social Security payments.

Defenders of the status quo will argue that rapid increases in outlays are justified by demographics or changes in hospital payment. I suspect that is not true.

Total physician payments are increasing rapidly. In contrast, the Medicare population is increasing at only 2 percent a year. According to the Physician Payment Review Commission, the aging of the Medicare population can account for less than one-tenth of 1 percent of the annual increase in outlays.

Changes in hospital payment also have very little effect on physician payments. Physician and hospital services are not substitutable. If anything, physician payments should decrease as a result of the prospective payment system.

Fees for outpatient physician services are usually lower than fees for comparable inpatient services. Under the DRGs-system, most physicians have a global fee which includes all services necessary and is absolutely unaffected by the length of stay in a hospital.

Furthermore, fewer services are generally used when illness is treated on an outpatient basis. The real problem is that fee-for-service medicine rewards physicians for providing more and more, even when additional services are unnecessary or may be of marginal value, as judged by their own peers.

So far, discussions of payment reform have focused on adjusting payment rates to correct geographic inequities and inequities between procedural and cognitive services. Emphasis has also been placed on limiting extra charges on unassigned claims.

In spite of the increase of the premium, very little is said about the $3, $4, or $5 billion of extra billing that our beneficiaries will have to pay out of their own pockets.

We now need to focus on the issue of volume. Without an effective control on volume, outlays will continue to spiral out of control. Developing policies that will prevent unwarranted increases in volume will be difficult and take time. We need to press ahead if the program is to remain affordable for the elderly.

Two closing notes. Our committee and our subcommittee has worked hard in the past to counsel with and listen to the advise of all providers. In several cases, we have come to agreements which we feel would have simplified and reduced the payment structure and would have saved money for the beneficiaries and the Government and would have been fair to the providers.

These agreements have been opposed by advocates representing physicians in this country with an unwillingness to negotiate.

I would like to submit that if we are going to do something before the pressure from the public mounts, forcing us to do something unwise and reactionary, that all parties to this problem come together. A little tension does not hurt, but contention seems to destroy our ability to make any changes.

The second part I would like to note is that increasing part B costs is not a valid argument against the proposed catastrophic coverage of whatever form, whether it is the one passed out of this committee or the one that is being considered in the Senate at this time.

If anything, the need for catastrophic insurance is made greater. Copayments are based on the level of Medicare payments and they have increased at an average annual rate of 15 percent; 3 million elderly now pay over $1,500 a year in Medicare copayments.

If the present course is followed, catastrophic insurance will protect the elderly from the impact of ever increasing, and the prospect of doubling, copayments in the next 5 years.

Under the House bill, these costs will be spread evenly on an income-related basis for the 30 million elderly.

I look forward to hearing from Dr. Roper and the other witnesses. I hope that we can all work together to see if we can control these spiraling costs.

Thank you very much, Mr. Chairman.

[The statement of Mr. Stark follows:]

THE HONORABLE FORTNEY H. (PETE) STARK
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
HEARING ON THE MEDICARE PART B PREMIUM FOR 1987
SEPTEMBER 30, 1987

Our responsibility is to ensure that health care remains affordable for the elderly and for the taxpayers. News of the proposed 39 percent increase in the Medicare Part B premium for 1988 highlights the challenge.

We must ask the Administration tough questions to be sure that the proposed increase is fully justified. But, the main problem appears to be rapidly increasing payments to physicians and other providers.

Over the past five years, Part B outlays have nearly doubled from $15 billion in 1982 to $30 billion in 1987. The five-year average growth rate is 15 percent a year. And this year, outlays are racing ahead by 22 percent.

These facts are striking. In an era of massive deficts, we need to ask some tough questions. Where is all the money going? Are we getting our money's worth?

Two-thirds of the increase in Part B spending is the result of ever-increasing payments to physicians. Over the past 5 years, total payments to physicians under Medicare have been increasing at an average rate of 14 percent a year.

* 55 percent of the increase in total payments is due to increases in the volume of services provided -- that is, more office visits, more tests, more X-rays, and more surgery.

* 30 percent of the increase is due to increases in price, including annual inflation increases.

* 15 percent is due to increases in the number of elderly and disabled covered by the program.

Despite all the complaints we hear, physicians are doing quite well. From 1980 to 1985, Medicare payments per physician increased at an average rate of 4.4 percent a year, after adjusting for inflation. This year, payments per physician will increase by 12 percent above inflation.

And physician income continues to increase. In 1986, the average physician earned $112,790 after expenses, a 10 percent increase compared with a 1.1 percent increase in the CPI.

Defenders of the status quo will argue that rapid increases in outlays are justified by demographics or by changes in hospital payment. But, these are red herrings.

Total physician payments are increasing by 14 percent a year. In contrast, the Medicare population is increasing by only 2 percent a year. And, according to the Physican Payment Review Commission, the aging of the Medicare population can account for less than one-tenth of one percent of the annual increase in outlays.

Changes in hospital payment also have little effect on physician payments. Physician and hospital services are not substitutable. If anything, physician payments should decrease as a result of prospective payment. Fees for outpatient physician services are usually lower than fees for comparable inpatient services. Furthermore, fewer services are generally used when an illness is treated on an outpatient basis.

The real problem is that fee-for-service medicine rewards physicians for providing more even when additional services are unnecessary or of marginal value.

So far, discussions of payment reform have focused on adjusting payment rates to correct geographic inequities and inequities between procedural and cognitive services. Emphasis has also been placed on limiting extra charges on unassigned claims.

We now need to focus on the issue of volume. Without an effective control on volume, outlays will continue to spiral out-of-control. Developing policies that will prevent unwarranted increases in volume will be difficult and will take time. But, we need to press ahead if the program is to remain affordable for the elderly and for taxpayers.

As a closing note, let me stress that increasing Part B costs should not be used as an argument against catastrophic insurance coverage. If anything, the need for catastrophic insurance is greater.

Part B copayments are based on the level of Medicare payments and have increased at an average annual rate of 15 percent a year over the past 5 years. Three million elderly now pay over $1,500 a year in Medicare copayments.

Catastrophic insurance will protect the elderly from the impact of ever increasing copayments. Under the House bill, these costs will be fairly spread on an income-related basis across thirty million elderly.

Mr. **Pickle**. Mr. Chairman, I do not have a prepared statement. I think the statements you and Mr. Duncan made are appropriate and accurate and pose the problem. But the comments of the gentleman who just finished seems to me to lay the predicate that the cause of this problem is strictly with physician fees and services.

This hearing is for the purpose of trying to understand why this 39 percent increase is proposed and I do not think we ought to impute automatically to the physician and physician services that they have been the ones who caused it all. Perhaps the freeze that we have had on physician payments in previous years, or perhaps the shorter hospital stays that we have encouraged through the DRGs ought to be considered.

There is no real evidence to point that this increase is caused strictly by the physicians. I just simply think, as a matter of fairness, we ought to hold this hearing to see if we can find an answer and not simply charge them before we even start.

I think we ought to recognize that there are two sides to this and we ought to examine the whole thing first.

Chairman **Rostenkowski**. Any further comments?

[No response.]

Chairman **Rostenkowski**. If not, we will first hear from the administration, represented by Dr. William Roper, of the Health Care Financing Administration. Dr. Roper, the committee is ready to receive your testimony.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. **Roper**. Thank you, sir.

Good morning, Mr. Chairman, members of the committee. I am pleased to have a chance to meet with you today to discuss the Medicare part B premium for 1988 and the all too rapid escalation in part B costs under the Medicare program.

As you have noted, we are publishing today in the Federal Register a notice that sets the premium for next year at $24.80, an increase of $6.90 over the current premium of $17.90.

What I would like to do in my testimony this morning is spend a few minutes on background information and please bear with me if this is tedious and detailed. You and the Ways and Means Committee are quite familiar with detailed matters, but I confess to you that this is a very complicated matter.

Part A of the Medicare program pays essentially for hospital services and it is financed by mandatory payroll deductions, Social Security taxes. Part B of Medicare, also called the supplementary medical insurance program, is a voluntary program financed from two sources, a monthly premium paid by beneficiaries and general revenues.

I have a chart that I would like to show you and you each have copies of this chart before you. It explains the nature of the premium over the past number of years. Those of you behind the chart have printed copies in front of you, so bear with us.

For the first nine years of the Medicare program the premium was set at 50 percent of part B costs. However, beginning in 1976, legislation linked the amount by which the premium could increase to the Social Security COLA. That had the effect of holding down the increase in the premium.

As you can see in the chart, the amount of the premium as a percent of part B outlays has dwindled over time. Between 1975 and 1983, part B outlays grew 17 percent per year. The Social Security COLA increased only 7.7 percent per year.

This led to Congress, in 1983, moving to halt further erosion in premium payments by requiring, in the statute, that the premium cover 25 percent of program outlays. Under this law our estimate of 25 percent of next year's program costs would make the premium $24.80 per beneficiary per month.

In 1989 and thereafter, under current law, premiums will again be limited by the cost of living increase in Social Security. By 1993, under current law, the part B premium will finance only 17 percent of part B outlays.

The Medicare statute requires the Secretary to promulgate a premium based on a monthly actuarial rate equal to one-half of the total benefits and administrative costs which are to be payable for total part B benefits. We are required to include a contingency margin for the trust fund, and this is included in the calculations.

The monthly premium, as I said, will increase to $24.80 next year. We had earlier projected, in the President's budget, that the premium would be $2 less than this. But higher program costs necessitates a higher premium.

There are three factors that explain this $6.90 increase in the premium. Adjusting prior year spending estimates that have now proven to be too low accounts for 35 percent of the increase. Projected spending increases from this year to next year account for another 43 percent, and a drawdown on the contingency fund this year contributes roughly 22 percent.

It is important to note that growth in program expenditures contributes to 78 percent of the increase in the 1988 part B premium. For both the unanticipated increase in part B spending for this year and projected increase for next year, the growth in expenditures for physician services contributes the bulk of the increase.

Effects arising from the drawdown of the contingency fund are 22 percent, as I said. The part B contingency fund is essentially equal to the cash balance of the trust fund, net of charges for services that have been provided but which have not been paid for.

This contingency fund need not be large, or even positive, because there is a cash float factor in that we incur bills but do not pay them for a few weeks. In fact, the contingency fund in this premium promulgation is negative. Our actuaries believe that a contingency approximately equal to 3.5 percent of the following year's projected incurred expenditures is optimum.

At the end of 1984, the contingency reserve was greater than what we considered to be adequate and therefore we decided to spend down that savings, so to speak. Premium rates were set at levels intended to spread or amortize the 1984 surplus over the years 1985 through 1987. Had we not spent from this reserve in these 3 years, the premiums would have been higher in 1985, 1986, and 1987.

We now know that our spending projections for the last year were too low and that the trust fund balance was therefore reduced somewhat more than we intended. The contingency reserve will be negative at the end of this year and at the end of next year.

We could have opted to rebuild this contingency to the optimum level in 1 year, to do it quickly, but this would have required, of course, an even higher premium than the one we are promulgating today.

The total contribution of this contingency policy to next year's premium increase is $1.50 of the $6.90 increase. Let me be clear. Decisions about whether and how much to draw down or build up the contingency fund in each year affect only the timing of the impact of increases in part B costs.

The important point is that part B premiums in the years 1984 through 1988 are driven by the growth in part B costs, not by our policy on the contingency fund. Increases in part B costs are the engine in the premium machine, so to speak. To have lower premiums, we need to control the growth in program expenditures.

Physician services represent about 65 percent of total part B payments and they effectively drive part B spending. Historically, Medicare physician spending has increased very rapidly, particularly relative to the growth in the general economy, as measured by the gross national product.

For example, between 1975 and 1983, physician spending under Medicare increased at a compound annual rate of 20 percent and the GNP increased about one-third this much. This growth produced a commensurate increase in physician incomes. According to the annual Medical Economics survey of physicians, median net physician income grew 31 percent between 1981 and 1986.

The long-term growth trend in Medicare physician spending slowed somewhat between fiscal years 1984 and 1986 when the hospital prospective payment system was implemented and the physician fee freeze was in effect. Medicare physician spending increased only 25 percent during these years, or compounded annual rate of 12 percent.

Still bear in mind, that is twice the growth in the GNP.

Medicare physician spending is increasing faster than non-Medicare physician spending. Therefore, the share of the physician market attributable to Medicare payments increased from 17 percent in 1980 to 21 percent in 1986.

I think you are asking, and we are asking, what is causing this overall 13.5 percent per aged enrollee increase in Medicare physician spending. We believe that over half is due to what we call the residual category. That is, what is left over after accounting for fee price increases and increases in enrollment.

The residual category includes increases on a per enrollee basis in utilization or volume of services, changes in the mix or intensity of services, and changes in technology and new services or benefits.

Let me show you the second chart that I have today.

What this chart shows is, over time, the growth in spending, after factoring out the increases in enrollment, compared to increases in prices over this period. The top line, the red line, is growth in spending per enrollee. So the increase in population has been factored out of that red line.

The bottom line is the percent increase in the medical component of the CPI, not the general CPI but the medical component. The difference in those two lines, the red line above the green line, one could argue, is the growth beyond what can be accounted for by a very generous price factor.

Spending soared in the early 1980s and only began to moderate, if you can consider 13 percent as moderation, with the implementation of hospital prospective payment in 1984 and the fee freeze in July of that same year.

With the end of the fee freeze, spending has again risen dramatically. But as you can see, at the end of the chart, we do not expect that very rapid rise to continue over time.

The main point of the chart, though, is the difference in the rate of spending per enrollee over the increase in prices. That is what is accounted for by the residual which we believe is utilization—increase in new services, increase in technology, changes in the mix of services.

It is not at all clear that these increases in utilization have improved the quality of medical care. That is certainly a subject over which much research is being done now and will be done in the future. But I think a number of thoughtful observers of medical practice in this country believe that much of what is done is questionable and some of what is done is unnecessary.

A number of hypotheses have been suggested to explain this rapid rise in part B spending under the Medicare program, and let me just deal with several of these quickly. It has been suggested, for example, that a constant part B deductible at $75 which has been eroded in real terms has led to more beneficiaries being over that deductible and a more rapid rise in spending.

This explains very little of the increase in part B costs. I can go into that in detail, if you wish.

Another hypothesis holds that increases in part B spending are due to a shift in service site from the hospital to the out-patient setting, as a result of the prospective payment system and so on. Again, however, this contributes little to explaining the growth in part B spending. Although spending for hospital out-patient department facility services is increasing, it is still much too small a piece of the whole to explain the increases in either physician or total part B expenditures that we are observing.

In considering physician payments, remember that the bulk of physician payment does not vary according to the site of service. Physician services in the hospital or physician services out of the hospital, those are still part B expenditures.

Another hypothesis that has been raised is that the Medicare population is aging. Not only do we have 2 percent more beneficiaries, but the whole cohort of people who are beneficiaries of Medicare are aging. Again, that contributes very little to the explanation because, on average in a given year, the population ages only 14 days. That accounts for only 60 cents of the projected $118 in increased outlays for next year.

Understanding the specific components of the increase in utilization of services is a difficult undertaking and we have a number of our data and computer experts working hard on improving our data systems. We will have better answers to these questions in the not too distant future.

Many people, myself included first, Secretary Bowen next, and a number of others in and out of the Department, have asked very good questions about what underlies the numbers that I am giving you today.

One of the things to bear in mind, in understanding this, is the magnitude of the claims processed by our carriers. Part B claims are projected to be 367 million next fiscal year. That is 1.4 million per working day. That is 30 times as many claims as we receive from hospitals. So the sheer magnitude of the data that we confront, in answering these questions, is enormous.

However, we have invested heavily in our research budget to answer these questions. A point I want to make is that despite our limitations in fully answering all these questions, some things are very clear. One is that there is a long standing trend in rapidly rising part B outlays in the Medicare program and a trend much in excess of the rise in prices for these services.

A second point, is that in the last year, we have seen a 20-percent increase in part B outlays under the Medicare program. So it is both a long standing trend and a recent rapid rise in outlays.

The dramatic increase in the premium that has brought us here today is perhaps most productively viewed as a symptom of this continuing high rate of growth in part B costs. A point that I want to stress in dealing with this issue is the importance of not just the price per unit of physician services and other part B services, but also the total number of those services, which we call utilization.

We believe that capitation approaches offer the greatest promise for successful long term reform of the Medicare payment system. What capitation does is put in the hands of people at the local level the ability to make decisions about services—whether or not they are needed, whether or not they will really benefit an individual patient, rather than us having to make those kinds of decisions here in Washington or Baltimore.

We believe that encouraging a variety of types of private plans to do business with the Medicare program, and offering that range of choices to Medicare beneficiaries, is the best way to let people who know those patients best make rational choices for the benefit of patients.

It is for that reason that we are pursuing a long term policy goal of greater availability of these private health plans to our beneficiaries. We have proposed legislation to expand beyond the current HMOs and competitive medical plans that are now available, and in which a million of our beneficiaries are enrolled.

We seek to do demonstrations to expand the kinds of plans that might be offered in the future. Frankly, we are frustrated somewhat in our efforts to test and proceed with these ideas by some recent actions in the Congress. Last year's reconciliation act imposed a prohibition on certain physician incentive payment arrangements, that are just the kind of arrangements that would give physicians the right kind of incentives to make choices about necessary utilization of services.

Also reconciliation language for this year would curtail our ability to move ahead with demonstrations in the capitation area.

We realize that it is unrealistic to expect our private health plan strategy to change the profile of the Medicare program overnight. Therefore, we believe it is prudent to apply some pressure on the fee-for-service system for the time being.

What I will do, in conclusion, is stress what we see to be the reasonable options in dealing with the fee-for-service system. Each of these options suffers from limitations and I want to go into those briefly with you, as well.

These four options are limiting payment fees, secondly providing more intensive claims review to eliminate unnecessary services, thirdly bundling services together and paying on a fixed price based on averages, and finally, directing beneficiaries to preferred provider networks that exclude providers with inappropriate practice patterns.

First and perhaps most obviously, one could limit the amount that is paid per unit of service, limiting fees. That could be done, and has been done, on a selected basis, looking at certain overpriced procedures. We and you have dealt with the issue of cataract surgery and anesthesia for cataract surgery. Also, we are developing in a study contracted to Harvard University, an RVS, relative value scale, that could be used to construct a fee system.

As important as that RVS information is for contributing to greater equity in physician payment, it does nothing about utilization, the volume of services. It is only useful as a price control mechanism.

Another point that I would stress, and that you all have debated and will debate in the future, is the appropriate level to set the Medicare Economic Index [MEI]. This index that is the amount by which the limit on physician payments may increase next year.

I would like to highlight an important point; that is, many physician's customary charges are below this limit. So simply freezing the MEI or making the MEI a cut in the prevailing charges is not going to directly impact on every physician's charges in the Medicare program.

The second point that I would make, or a second possible option is more intensive claims review; that is, looking more carefully at individual units of service to determine whether they are necessary. In 1988 we propose to expand our medical review activities performed by the carriers by about 40 percent. We believe that this will bring in a return of more than seven to one in eliminating unnecessary payments.

But here again, I would point out a limitation of this activity. What we are talking about is scrutiny of what decisions individual physicians are making, looking over their shoulders, making decisions that deny payment. That is just the sort of decisions that your constituents write you about and you write me about, and we get hassled about. So understand what we are talking about when we say intensive claims review.

That sounds nice, but there is a lot of gray area in these decisions and it is not just enough to eliminate payment for the fraction of services that are obviously unnecessary. We have to cut into the gray area before we have any real impact on payment levels.

A third possibility is bundling payments together, and making payments based on averages. This increases incentives to provide only medically necessary and appropriate services. The President's budget this year included a proposal of that sort, dealing with radiology, anesthesiology, and pathology services.

Finally, a fourth possibility is developing within the Medicare program—preferred provider organization (PPO) networks. This is the sort of thing the private sector, Blue Cross and Blue Shield and private insurance companies, are doing at a great rate. The idea here is to direct beneficiaries to selected providers and then have the administrators of such a plan enroll providers that offer high quality care at favorable prices.

Provider performance would be assessed through intensified utilization review and poor performers would be excluded from this network. Through the operation of such review and financial incentives, the program might bring needed pressure to bear on the volume and level of intensity of services, resulting in more appropriate utilization.

There are a number of issues to be considered in developing a Medicare PPO network—for example, how beneficiaries could be encouraged to use such PPO providers; whether we would be able to attract sufficient numbers of providers into a network though incentives; and whether we can really do efficacious utilization review to weed out providers of inappropriate care.

As you all know well, getting a handle on the rapid growth on part B program outlays is a longstanding problem. It is one that has plagued both Republican and Democratic administrations since the beginning of the Medicare program. There are just not any easy or quick solutions.

We prefer the reforms we have proposed, especially focusing on capitation, but the Administration supports savings provisions that slow the growth rate in Medicare part B spending, such as freezes in physician payment for nonprimary care services.

I want you to know that I recognize the importance of this problem and am committed to working with you in solving it together.

Thank you very much.

[The statement of Dr. Roper follows:]

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
SEPTEMBER 30, 1987

Mr. Chairman and Members of the Subcommittee. I am pleased to be here today to discuss the Medicare Part B premium for 1988 and the all to rapid escalation in Part B costs. Today, as required by statute, we are publishing a notice announcing the premium in the Federal Register. As you are aware, the notice sets the premium for next year at $24.80, an increase of $6.90 over the current premium of $17.90.

Background

I would like to begin by placing this year's increase in its historical context. Since its inception, Medicare has been composed of two parts; Part A, the Hospital Insurance program, which principally covers inpatient hospital services, and Part B, the Supplementary Medical Insurance program, which covers physician and other outpatient services. Part A is financed through mandatory payroll deductions, while Part B, a voluntary program, is financed from two sources: a monthly premium paid by beneficiaries and general revenues.

For the first nine years of the program, beneficiaries and the Federal government contributed equally to finance the Part B program. Beginning in 1976, however, legislation required that the premium be set at the lower of one-half of projected Part B costs (for the aged beneficiary) for the next year, or last year's premium increased by the cost of living adjustment, or COLA, given to Social Security beneficiaries. Between FY 1975 and FY 1983, Part B outlays grew 255 percent, or 17.2 percent annually. During the same period, the Social Security COLA increased benefits by 81 percent in total, or 7.7 percent annually. Since Part B costs grew more than three times as fast as Social Security benefits, and since the Part B premium increase was restrained by the COLA, the share of Part B costs borne by beneficiaries through premium payments fell from 50 percent to around 24.8 percent for FY 1983.

In response, Congress moved to halt further erosion of premium payments by requiring that the premium cover 25 percent of estimated Part B program outlays for calendar years 1984 to 1988. Over this period, the premium has grown about 14.2 percent annually (almost 70 percent), from $14.60 for calendar year 1984, to the current 1988 premium of $24.80. Over the same period, program costs have increased at the same rate.

In 1989 and thereafter, under current law, premiums will again be limited by the cost of living increase. Since we expect Part B outlays to grow 66 percent over the next 5 years, or 2.6 times as fast as the COLA, we estimate that, by 1993, the Part B premium will only finance 17 percent of Part B aged outlays. The Administration has proposed making permanent, for current enrollees, the present requirement that premiums finance 25 percent of costs. In addition, the premium would be set at a higher level for all other enrollees. Maintaining the premium at 25 percent of program costs for all enrollees alone would reduce the Federal deficit by $1 billion in FY 1989 and by $6 billion over three years (FY 1989 to FY 1991).

Methodology for Setting the Premium

For calendar years 1984 through 1988, the Medicare statute requires the Secretary to promulgate a premium based on a monthly actuarial rate equal to one-half of the total benefits and administrative costs which are estimated to be payable for Part B services to enrollees aged 65 and over. In calculating the monthly actuarial rate, the Secretary is required to include an appropriate amount for a contingency margin for the Part B trust fund.

Explanation of the 1988 Premium Increase

In 1988, the monthly Part B premium will increase to $24.80, an increase of $6.90 or 38.5 percent over the current premium of $17.90. In the President's FY 1988 budget, we had projected a 1988 premium of $22.80. Faster program growth, however, necessitates a higher premium.

Three factors explain the 6.9 increase: adjusting prior years' spending estimates that proved too low accounts for 35 percent of the increase; projected spending increases from 1987 to 1988 account for 43 percent; and the draw-down on the contingency in 1987 contributes roughly 22 percent. (See Table 1) I would like to elaborate on these findings presently.

As noted, growth in program expenditures contributes 78 percent of the increase in the 1988 Part B premium. This translates into $5.40 of the $6.90 increase, and the $5.40 can be broken down into two pieces: spending in 1987 that exceeds projections, and projected spending increases from 1987 to 1988.

Our projections of 1987 expenditures at the time the 1987 premium was promulgated were nearly 11 percent lower than our current estimates of spending for 1987. Were we to recalculate the 1987 premium based on current estimates, it would be $2.40 higher than it actually is. This difference accounts for 13.4 percentage points of the 38.5 percent increase in the premium for 1988. Increases in physician spending alone account for over 90 percent of these 13.4 percentage points.

Totally apart form those unanticipated increases in costs in 1987 are expected increases in costs in 1988. Current actuarial estimates show an increase in Part B spending of 13.9 percent for 1988. This growth accounts for $3.00 of the $6.90 increase in the 1988 premium, or 16.7 percentage points of the 38.5 percent increase. Physician spending is responsible for the lion's share -- 63 percent -- of that 16.7 percentage point increase.

In summary, for both the unanticipated increase in Part B spending in 1987, and the projected increase in Part B spending in 1988, growth in expenditures for physicians' services constitutes the bulk of the increase. Increases in physician spending explain $4.05, or nearly 60 percent of the $6.90 jump in the 1988 premium.

Effects arising from the contingency fund constitute the remaining 22 percent of the increase, or $1.50 of the $6.90 increase. The Part B contingency is essentially equal to the cash balance of the trust fund net of charges for services that have already been provided but which have not yet been paid. The purpose of the contingency is to maintain reserves adequate to cover unexpected events or circumstances. In addition to the contingency, there is a built-in cushion in the trust fund due to the time lags between both the provision of a service and when a bill is sent to our contractor, and receipt of a bill and actual payment. The Part B contingency need not be terrible large, or even positive, given the built-in cash float and the fact that the financing of the trust fund is adjusted annually when the premium is promulgated. In fact, the contingency in this premium promulgation is negative.

The actuaries believe that a contingency equal to approximately 3.5 percent of the following year's incurred expenditures is the optimum level. However, given the volatility of the trust fund expenditures, the optimal level serves only as a target. In some years the contingency is larger in than 3.5 percent, in other years smaller. In either case, our policy has been to move in the direction of the optimal level, usually over the course of a number of years, in order to minimize dramatic swings in the premium.

At the end of 1984, the contingency reserve for Part B exceeded the adequate level. Net assets totalled $6.3 billion. (Table 2) Consistent with our approach of correcting surpluses and deficits over a period of years, premium rates were set at levels intended to spread or amortize the 1984 surplus over the years 1985 through 1987. In each of these years, to reduce the reserve to the appropriate level, the Part B premium promulgated by HCFA was lower than the amount that would have been necessary to finance 25 percent of incurred expenditures because of the draw down from the contingency reserve. Had we not spent from the reserve in these three years, the premiums would have been higher by $0.64 in 1985, $0.83 in 1986, and $1.43 in 1987, before rounding.

Thus, if we had not reduced the 1987 premium by drawing on the contingency reserve, the increase in the 1988 premium would have been less dramatic, and we also could have drawn on the higher reserves to reduce the 1988 premium increase further. However, we expect that approach to the 1987 premium would have laid us open to criticism that we were charging an unjustifiably high premium, given the large contingency reserve at that time. When the 1987 premium was promulgated a year ago, we were projecting net trust fund assets of about $ 7.7 billion at the end of 1985, $5.1 billion at the end of 1986 and $3.2 billion at the end of 1987.

Based on more recent data, we now know that our spending projections for last year were too low and that the trust fund balance was therefore reduced somewhat more than intended. Moreover, the contingency reserve will be negative at the end of 1987 and 1988. However, given the cash float, the trust fund will be able to maintain payments. The actuaries estimate that the cash balance at the end of 1988 will be sufficient to finance an additional 1.7 months of trust fund outlays.

Although, the trust fund will be able to continue to make payments with the negative contingency, this is clearly not the optimal way to finance the trust fund. We could have opted to rebuild the contingency to the optimal level in one year. This would have required, however, that the premium increase be approximately $2.00 higher. Given the $6.90 increase already planned, this option was not viable. Therefore, we again decided to move the contingency back toward the optimal level over a number of years. The premium we have established for 1988 includes 6.5 cents to prevent further reduction in the contingency. Including the effect of the $1.43 reduction in the contingency in the 1987 premium, the total contribution of the contingency policy to the 1988 premium increase is $1.50, or 8.4 percentage points of the 38.5 percent increase.

While the Part B contingency policy bears on the year-to-year changes in the premium, it does not affect the total premiums paid by beneficiaries over a number of years. Decisions about whether and how much to draw down or build up the contingency fund in each year affect only the timing of the impact of increases in Part B costs.

The important point is that the Part B premium in the years 1984 through 1988 is driven by growth in Part B costs, not by our policy on the contingency fund. The annual rate of increase in the premium between 1984 and 1988 is 14.2 percent, consistent with the 14.4 percent annual rate of growth in incurred Part B spending per enrollee benefits during that period. To speak figuratively, then, increases in Part B costs are the engine in the premium machine. To have lower premiums, we need to control the growth in program expenditures.

Increases in Physician and Other Part B Spending

Part B spending is attributable primarily to spending for physician and other medical services (76 percent) and hospital outpatient services (20 percent). Group practice prepayment plans and other services account for the remainder of Part B spending. Physicians' services comprise about 85 percent of the physician and other medical services category. (Other medical services include durable medical equipment, ambulance services, laboratory services, etc.). Thus, physicians' services, representing about 65 percent of total Part B payments, effectively drive Part B spending.

Historically, Medicare physician spending has increased very rapidly, particularly relative to growth in the general economy, as measured by the Gross National Product (GNP). Between FY 1975 and FY 1983, it increased 342 percent or at a compound annual rate of 19.7 percent. The GNP increased about one-third this much (113 percent or at a compound annual rate of 9.9 percent) during this period.

This growth produced commensurate increases in physicians' income. According to the annual Medical Economics survey of physicians, median net physician income grew 30.8 percent between 1981 and 1986. The CPI grew by 20.6 percent in the same period.

The long-term growth trend in Medicare physician spending slowed somewhat between fiscal years 1984 and 1986, when the hospital prospective payment system was implemented and the 22-month freeze on physician fees (30 months for non-participating physicians) was in effect. Medicare physician spending increased only 24.6 percent during these years, or at a compound annual rate of 11.6 percent. Notwithstanding the Medicare fee freezes, this was still double the growth in the GNP. Thus, the persistent high rate of increased Medicare expenditures for physician services continues to pose a problem.

The national health expenditures data series offers further insight into the Medicare physician spending phenomenon. The data show that Medicare physician spending is increasing faster than non-Medicare physician spending. Between 1980 and 1986, Medicare physician spending increased 60 percent more than non-Medicare physician spending [141 percent versus 88 percent] and more than two and a half times as much as the GNP [54 percent]. As a result, the share of the physician market attributable to Medicare payments increased 22.5 percent, from 16.9 percent in 1980 to 20.7 percent in 1986. This figure compares to an increase of only 11.7 percent in the beneficiary population over this period.

What is causing the overall 13.5 percent per aged enrollee increase in Medicare physician spending? We believe that over half is due to what we call the residual category, which includes increases on a per enrollee basis in the utilization or volume of services; changes in the mix or intensity of services; and changes in technology and new services or benefits. Increases in the utilization of services include increases in the volume of services such as ambulatory visits, and lab and radiology tests, as well as fragmentation of services, producing an increase in the number of bills for a given service or bundle of services. Changes in the mix or intensity of services include both real and reported changes in services (e.g., new and more complicated services as well as upcoded services).

It is not at all clear that these increases in intensity have improved the quality of medial care. The research of John Wennberg and Philip Caper on practice patterns indicates that wide variations in practice patterns exist without producing clinically meaningful differences in health outcome. HCFA's research agenda with regard to practice variations is very active. In particular, the RAND practice pattern study is finding that many procedures are performed for inappropriate indicators.

It has been suggested that physician and other Part B costs are increasing because an increasing percentage of Medicare beneficiaries are using sufficient services to exceed the deductible. The value of the annual Part B deductible, which has stayed at $75 since 1982, is eroding due to inflation, with the result that more beneficiaries meet it. Nevertheless, very little of the increase in Part B costs can be attributed to this factor. Between fiscal years 1982 and 1986, the percentage of aged Medicare enrollees whose spending for Part B services exceeded the deductible increased by 2.5 percentage points per year from 67.9 to 77.8. The increase in Part B expenditures attributable to beneficiaries who cross the deductible threshold due to its declining real value is minimal because the amount by which they exceed the deductible is very small.

Another hypothesis holds that increases in Part B spending are due, in part, to a shift in the delivery site of services from inpatient to outpatient settings, as a consequence of the hospital prospective payment system or the activity of Peer Review Organizations. This movement would cause a shift from Part A to Part B, resulting in a greater rate of increase in Part B outlays. This hypothesis, however, contributes little to explaining the growth in Part B spending. Although spending for hospital outpatient department facility services is increasing, this sector is too small a piece of the whole to explain the increases in either physician or total Part B expenditures that we are observing. considering physician payments, the bulk of physician services does not vary according to the site of service (i.e., hospital inpatient setting vs. hospital outpatient department vs. physician office), shifts of services from inpatient to outpatient settings should not much affect physician spending. In fact, it has been argued that the shift toward outpatient settings might be slowing growth in physician spending if, for example, physicians perform fewer consultations and lab tests here, as some speculate they do. The redistribution from Part A to Part B of costs associated with facility services and non-physician services such as laboratory tests is also too small to explain the high growth in Part B spending.

The aging of the Medicare population has also been offered as a possible explanation for the growth in Part B outlays. However, this factor will contribute very little to projected increases in Part B spending in 1988. In fact, it is estimated that it will account for only 60 cents of the projected $118.17 increase in part B benefits per aged beneficiary for the year ending June 30, 1988. This amounts to $ 17 million of the projected increase of $3.9 billion of incurred benefits for the elderly during that period.

Understanding the specific components of the increases in the utilization of services is a difficult undertaking for several reasons. In the past few years we have devoted significant resources to developing a new Part B data base, known as the Part B Medicare Annual Data System, or BMAD. Our goal in developing this system is, precisely, to be able to understand and describe characteristics of Medicare payments to physicians and other Part B providers. Unfortunately, our efforts to develop comparative historical data have been hampered by the lack of a common procedure terminology and coding system across carriers, prior to 1984-1985. Time lags between the actual provision of services and the accumulation of complete data for the time period in which those services were furnished also complicate analysis. Additionally, the magnitude of the claims volume processed by carriers -- projected to be 367 million claims in FY 1988 or 1.4 million per working day -- presents a formidable task. Finally, carrier claims processing systems vary and this leads to differences in the way information from bills are processed and stored and to inconsistencies in national comparative data.

To understand what is causing the increase in Medicare physician spending, HCFA has funded cooperative agreements with the Center for Health Economics involving 10 states from 1983 to 1988. The researchers will disaggregate the components of the increase. However, no results are expected before early 1988 and full results will be available in mid 1990.

Our research and demonstrations grants solicitation, published on September 10 in the Federal Register, emphasizes our major commitment to better understanding characteristics of and trends in physician payment, and identifying recommendations for changes in Medicare physician payment policy.

Options

The dramatic increase in the premium for 1988 is perhaps most productively viewed as a symptom of the continuing high rate of growth in Part B costs. To control these increases effectively over the long term, it will be necessary to address both price and utilization.

For these reasons, the Administration is pursuing as a long-term policy goal greater availability to Medicare beneficiaries of pre-paid health care options. To further the availability of private health plan options to Medicare beneficiaries, the Secretary has proposed legislation that would enable HCFA to enter into risk contracts with employers and unions, permitting these entities to combine their supplemental benefits with the Medicare benefit, for their Medicare-eligible retirees and annuitants. Such arrangements would pave the way for employers and unions to rationalize and perhaps enrich the health coverage they provide, and would allow their retirees and annuitants to come on to the Medicare rolls without disruption of their existing relationships and routines with health care providers. The Department has also planned demonstrations of this concept, generally called the MIG or Medicare Insured Group demonstrations.

We have been frustrated in our efforts to test and proceed with these ideas, which we believe have important potential, by several recent actions in the Congress. The Omnibus Budget Reconciliation Act of 1986 included a provision prohibiting physician incentive plans which, when it takes effect January 1, may seriously impair the ability of HMOs and CMPs to structure incentive arrangements that encourage physicians to reduce inappropriate utilization. The prohibition may undermine the viability of HMO/CMP risk contracts, effectively denying senior citizens the benefits of this important feature of the medicare program.

In addition, Committee reconciliation language for FY 1988, if enacted, would severely curtail our ability to move ahead with MIG demonstrations. These restrictions slow our progress toward greater control over physician and Part B spending, even as we struggle together to solve this problem.

We recognize that it is unrealistic to expect our private health plan strategy to change the profile of the Medicare program in the near term, making capitation the predominant mode of health services delivery and reimbursement. Therefore, we believe it is important to apply some pressure on the fee-for-services system.

While each suffers from limitations, we have identified four broad conceptual approaches to controlling escalating costs in this environment:

- limit payment fees;
- provide intensive claims review to eliminate unnecessary services;
- bundle services and pay a fixed price based on averages; or
- direct beneficiaries to preferred provider networks that exclude providers with inappropriate practice patterns;

Limit payment fees. HCFA strongly supports steps to remedy situations where Medicare reasonable charges are overpriced. Last year we proposed reductions for cataract surgery which were incorporated in the Omnibus Budget Reconciliation Act of 1986. We strongly support the actions taken by this committee in the FY 1988 reconciliation bill to reduce payment for certain overpriced procedures. HCFA has a strong program of operational reviews of selected procedures, research on identification of overpriced procedures and research to develop a relative value scale (RVS) system.

Nevertheless, we are pessimistic that an RVS system will effect meaningful large-scale reform of physician payment or successfully control spending in this area. Such an approach may improve perceptions of equity among physicians. However, past experience tells us that physicians will respond to price reductions or payment redistributions that will occur under an RVS system by increasing volume, perhaps leaving us in a worse situation than we are in now.

Intensive claims review to validate medical necessity and appropriateness of the level of care can greatly reduce payment for unnecessary services and cut program costs. In FY 1988, we propose to expand our carrier medical review activities by about 40 percent to over $74 million. These activities will save the Part B program almost $520 million, a return of better than seven to one. But clearly there are limits to this approach imposed by system capacities and perceptions of arbitrariness by beneficiaries and providers.

Bundled payments and fixed prices based on averages represent another option to achieving Medicare payment reform. By establishing a fixed prospective payment, this approach would increase incentives to provide only medically necessary and appropriate services, similar to incentives operating in the successful hospital DRG system.

The President's budget for FY 1988 included a proposal to bundle payments for radiology, anesthesiology and pathology (RAP) services into a single payment amount for hospital-based physicians' services. This approach recognizes the unique relationships that physicians providing RAP services have with hospitals and patients. Traditionally, these physicians maintain a hospital-based practice and have a contractual arrangement or other close relationship to the hospital. Their relationships with individual patients are distinctive from those of attending physicians in several ways: usually, the patient has no opportunity to select these physicians, their services are dependent upon the attending physician's orders or decision for surgery, and their care for the patient ends with discharge. These factors make a DRG-based payment for RAP services more feasible and advisable than one for all inpatient services.

Preferred provider networks. Increasingly, the private sector is making use of preferred provider networks, or PPOs, to direct beneficiaries to selected providers. Plan administrators enroll providers that offer high quality care at favorable prices. Provider performance is assessed through intensified utilization review and poor performers are excluded from the network. Perhaps the PPO approach could be used effectively to make changes in Medicare. We could contract with PPO administrators, possibly existing carriers, to organize and manage Medicare PPOs in their areas. Through the operation of utilization review and financial incentives, the program might bring needed pressure to bear on volume and level of intensity of services, resulting in more appropriate utilization and patterns of service.

Issues to be considered in developing a Medicare PPO include: how beneficiaries could be encouraged to use the PPO providers, whether expected patient volume and other incentives would be sufficient to attract providers to join the network, and whether efficacious utilization profiles could be developed to weed out providers of inappropriate care.

As the members of this Committee know well, getting a handle on the rapid growth of the Part B program is a problem that has plagued the Congress and both Republican and Democratic Administrations since the beginning of the program (except during the Economic Stabilization Program of 1971-1973). There are no easy or quick solutions. Although we prefer the reforms we have proposed, the Administration supports savings provisions that slow the growth rate in Medicare Part B spending such as freezes on physician payment for non-primary care services. Such provisions would help slow future beneficiary premium hikes and future jumps in the Federal deficit from soaring Medicare Part B costs.

I want to emphasize today that I recognize the importance of this problem. I am committed to working with you to find acceptable and effective ways to control the rapidly escalating Part B costs that are placing an unacceptable burden on beneficiaries and on the Federal budget.

Table 1

COMPONENTS OF INCREASE IN 1988 PART B PREMIUM FROM $17.90 TO $24.80

Total increase in premium	($6.90; 100%)		38.5%
Correction for prior projections	($2.40; 35%)		13.4%
Physicians' reasonable charges		12.1%	
Group practice prepayment plans		2.2%	
Other categories		-0.9%	
Program growth, 1987-88	($3.00; 43%)		16.7%
Physicians' reasonable charges		10.6%	
Outpatient hospital & other institutions		4.3%	
Group practice prepayment plans		1.3%	
Independent lab		0.5%	
Home health agencies		0.0%	
Contingency reserve	($1.50; 22%)		8.4%
Completion of spend-down		8.0%	
Build-up for 1988		0.4%	

TABLE 2
Actuarial Status of the SMI Trust Fund
1967-1988
(Dollar Amounts in millions)

	CASH (CY)		INCURRED	
	Balance in trust fund	Excess Ratio /1 (in months)	Excess of assets over liabilities	Incurred Ratio /2
			As of June 30,	
1966	122	1.12		
1967	412	2.90	77	0.048
1968	421	2.45	(104)	-0.053
1969	199	1.08	(238)	-0.111
1970	188	0.95	(497)	-0.212
1971	450	2.07	(323)	-0.127
1972	643	2.71	(161)	-0.057
1973	1,111	3:58	(64)	-0.018
1974	1,506	3.82	244	0.056
1975	1,444	3.08	270	0.051
1976	1,799	3.32	(3)	0.000
1977	3,099	4.80	627	0.084
1978	4,400	5.70	1,770	0.201
1979	4,902	5.23	2,483	0.235
1980	4,530	3.88	1,768	0.139
981	5,877	4.35	788	0.054
982	6,230	3.94	2,783	0.158
1983	7,070	4.13	3,988	0.200
			As of December, 31	
1984	9,698	4.87	6,297	0.265
1985	10,924	4.80	7,624	0.272
1986	8,291	3.10	3,185	0.096
*1987	4,793	1.56	(1,494)	-0.039
*1988	6,184	1.75	(1,417)	-0.033

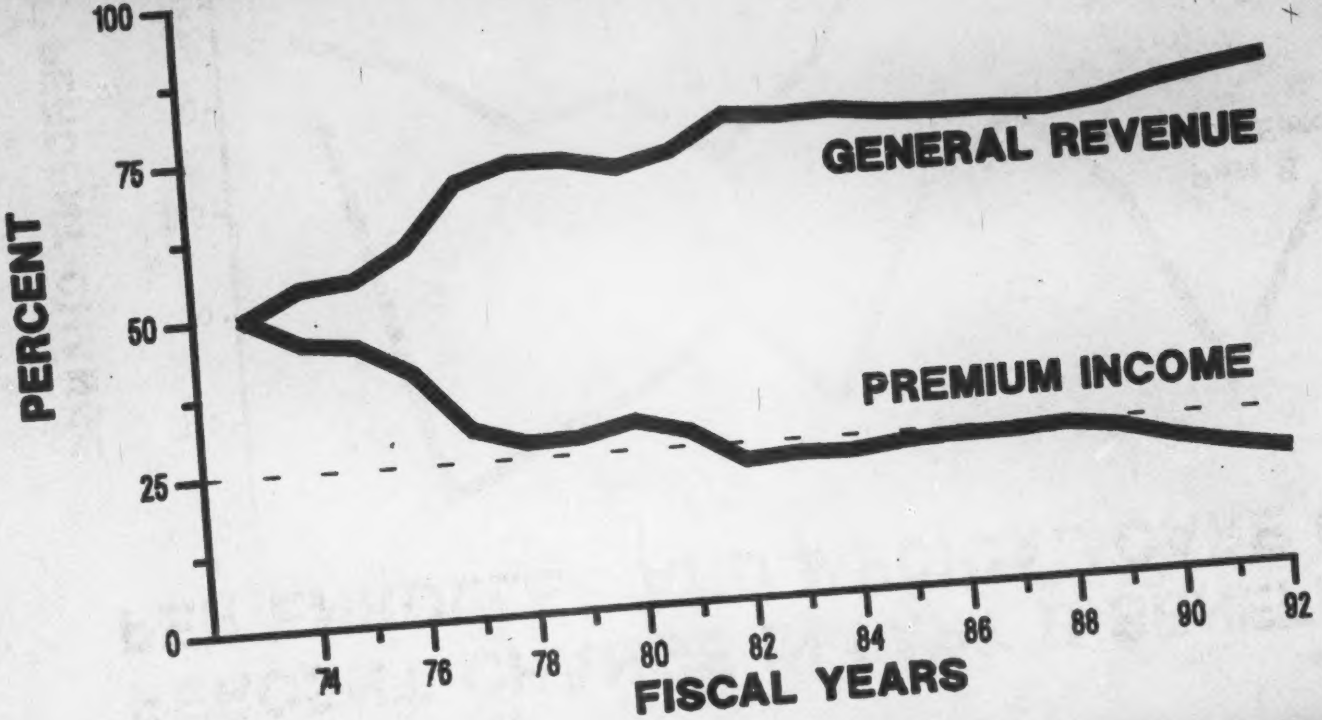
* Projected.

/1 Number of months of Trust Fund outlays that could be financed by end of year cash balance.

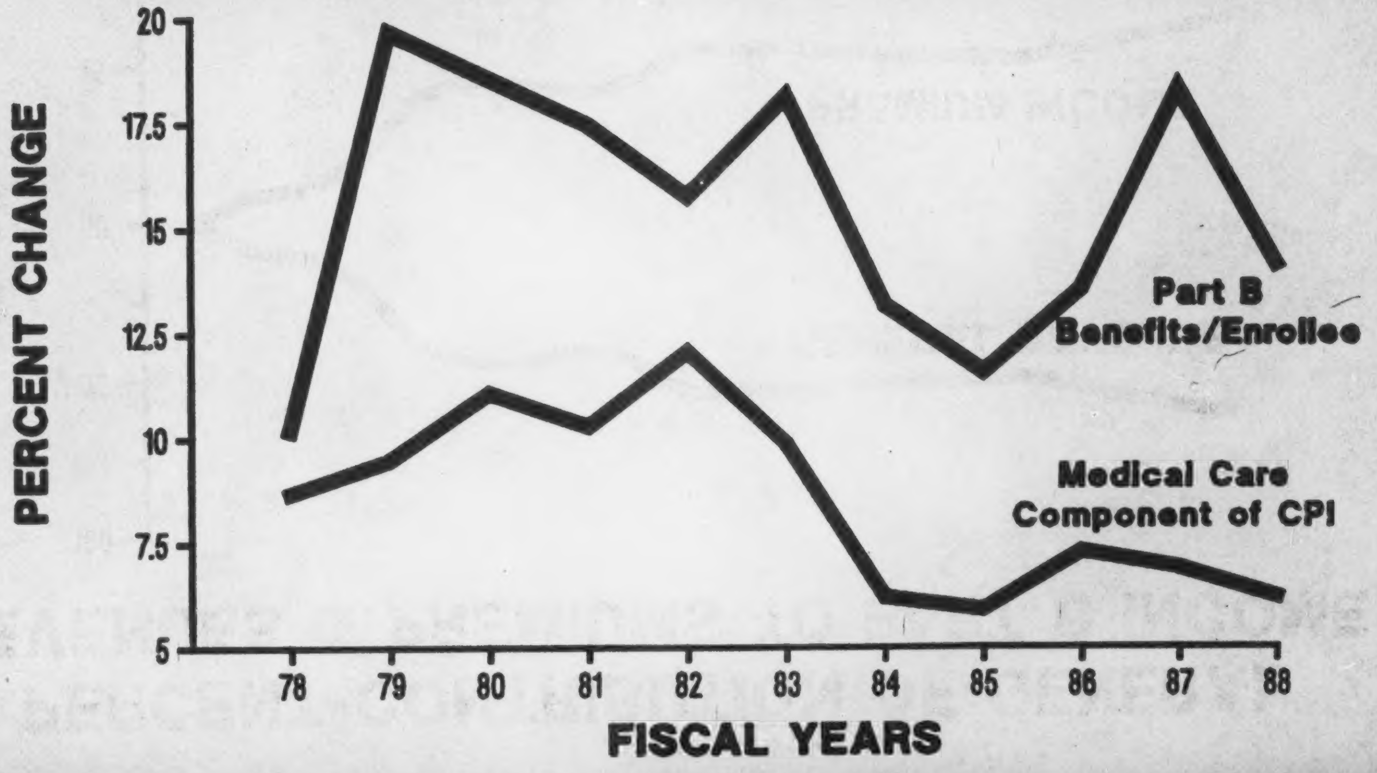
/2 Ratio of assets less liabilities at the end of the year to total incurred expenditures for the following year.

SOURCE: 1987 Annual Report of the Board of the Trustees of the Federal Supplementary Medical Insurance Trust Fund.

PERCENT CONTRIBUTION OF GENERAL REVENUES & PREMIUMS TO PART B INCOME



PERCENT CHANGE IN PART B BENEFITS PER ENROLLEE AND MEDICAL CARE CPI



Chairman **Rostenkowski**. Thank you, Dr. Roper.

Dr. Roper, we have two problems. First, the short-term problem of the large increase in the premium that will increase financial problems to the elderly and the disabled. Then we have a long-term problem of getting control of part B physician costs.

As concisely as possible, tell me how the Administration would suggest Congress proceed in addressing these problems?

Dr. **Roper**. The first problem being the premium amount itself?

Chairman **Rostenkowski**. Yes.

Dr. **Roper**. The premium we are promulgating is one that we believe is appropriate. What I would have you do on that score is understand the need for a $24.80 premium and be motivated by that rapid increase to come to terms with the second problem.

Chairman **Rostenkowski**. Doctor, is that the 25 percent? Has not the administration suggested 30 percent on occasion?

Dr. **Roper**. Yes, sir, in our budget. The President's budget proposes that for next year, current beneficiaries continue at 25 percent but that new enrollees be required to pay 35 percent. But for current beneficiaries, it would remain at 25 percent. I believe that is prudent and ought to be continued in the longer term.

Chairman **Rostenkowski**. What about part B physician's costs? How do you recommend we do something about that?

Dr. **Roper**. Over the longer term, we believe that the means to constrain growth in part B outlays is through capitation, enrolling Medicare beneficiaries in private health plans that have incentives to constrain unnecessary utilization.

In the shorter term, we believe that price restraint on an individual basis or a generalized basis, such as limiting the rate of increase in the Medicare Economic Index for all except primary care physicians, is something that ought to be considered.

Also, we are looking carefully at this question of a preferred provider network within the Medicare program. Those are the kinds of options that I think need to be looked at carefully and debated.

Chairman **Rostenkowski**. Mr. Pickle.

Mr. **Pickle**. Thank you, Mr. Chairman.

Dr. Roper, we have got a problem here and HCFA has the difficult task now of proposing this increase in the part B premium. I think we all recognize that the important thing now is to decide what if anything we can do to control outlays and if your four proposals are appropriate steps, which they may well be.

I think it is important for us to observe first that this premium increase is partially due to the decision made in 1985 either by HCFA or Congress, spent down the reserve. We held the premium down in order to spend down the reserves. Now that the reserves are gone, all at once we are facing a big jump.

That is probably the heart of this problem. We have spent down our reserve while our outlays continue to increase. It ought to be made clear that the decision we have made together, over the years, has partially caused this increase.

Dr. **Roper**. Twenty-two percent of this increase is accounted for by that spending of the savings, yes, sir.

Mr. **Pickle**. The fact is that we have spent down our reserves and now we face the problem that we have got to increase the premiums.

Has HCFA given this committee a breakdown on the various costs of the increase of physicians' fees? You have made some reference this morning to percentages. I have not seen those percentages before.

Dr. **Roper**. Sir, we have given your staff the information that we have. There was a detailed briefing last Friday. We would be glad to go over that with you personally.

Mr. **Pickle**. I have not seen them, and I do not know that the staff has got a complete breakdown about how these costs have come about and in what categories. Until we know that, it seems to me like we may be trying to point a finger before we know the facts on it.

Let me ask you, on page 3 of your testimony, you suggested that the premium would go up now from $22.80 to $24. You projected the premium at that $22.80 level. That was in the President's budget.

We proceeded through the year accepting that figure and passed a catastrophic insurance bill, very much needed by this Nation. We based our projections on the fact that, even if we entered into this field, the premiums would go up automatically from about $17 to $22.80.

Now we are told that they will go up considerably more, a great deal more. Why were we not told that during the markup of the catastrophic care bill? This comes as rather a surprise to me. Perhaps we should have known it. But you were relatively quiet, and all at once we are told that there is to be a 39 percent increase. Why were we not told when we were marking up the catastrophic care bill?

Dr. **Roper**. Mr. Pickle, the increase over the President's budget is $2, from $22.80 to $24.80. We are required by law to promulgate the part B premium by September 30, which we are doing. This is information that just came to light within the last few weeks.

Mr. **Pickle**. Dr. Roper, I do not want to get in an argument with you, but you say all these increased costs have just come to light in the last few weeks. You have not been living in a vacuum down there, as if all at once you woke up one morning and were told, as a big surprise, that these costs have gone up much. Have you?

It would seem to me that you would have a better idea.

I do not know that any explanation would answer the problem we have here at the committee, because if the premiums have gone up, they have gone up. The real problem is trying to ascertain what is the proper response to these costs and how to go about accomplishing it. I just think that the committee should have been given more information on this situation than we have.

I noticed over on pages 9 and 10 of your testimony, you point out some of the reasons why this is happening, what has caused this overall increase. You said that half of it was due to the residual category. Then you said that it goes back to the per-enrollee cost. That is the basis of utilization.

Are you saying that there has been over-utilization of services? Are you saying that we should not buy better equipment or give enrollees better treatment? What do you say in response to the fact that under DRG we are getting patients out of the hospital quicker? Is that not a factor to explain why this has come about?

Dr. ROPER. I dealt with each of those in my testimony, sir, but I will be glad to go back over them. The explanation of patients being treated out of the hospital instead of in-hospital under PPS does not explain anywhere near all of the increase in part B spending. It only explains a small part of it, as a matter of fact.

To get to the heart of your question, though, you ask am I saying that this utilization is unnecessary. What I am saying is I believe that some of it is. Some is a vague word.

Mr. PICKLE. Do you have a study that shows the break down of those figures? I have not seen that break down, if you have, those categories. Is that just a personal opinion or do you have facts on it?

Dr. ROPER. No, sir.

Mr. PICKLE. If you do have a factual presentation, you ought to give it to the committee.

Also, in that same connection now, and I do not want to argue with you, but it seems to me like you make some strong statements. You say in spite of these increases in utilization, there has been no showing of improved quality in medical care. Why do you make that statement?

Dr. ROPER. I would be glad to respond to you.

Mr. PICKLE. You seem to say physicians are overcharging and not giving better service? Surely you do not mean that.

Dr. ROPER. I would be glad to respond to you.

What I am saying, sir, is that there is enormous variation in the utilization of services from one region of this country to another. There is no evidence that that greater utilization in some areas accounts for their having better health status. They are not healthier in an area of the country that has a high utilization than in an area that has a low utilization.

That is one factor that leads me to my conclusion of a moment ago that some of this is unnecessary.

A second thing that leads me to that conclusion is a large body of research that has looked carefully at individual cases, individual physician decisions. For example, the Rand Corp., is working on a series of studies looking at these kinds of questions.

The Rand study deals with detailed decisions made by physicians. For example, they have looked at decisions to do coronary artery bypass grafts and found that 30 percent of the cases involved were questionable as to whether the individual really needed a coronary artery bypass graft and another 14 percent were clearly inappropriate. So 14 percent were for sure not needed and 30 percent may not have been needed.

I have only given you one example of a large body of evidence that leads me to conclude, not that all of this is unnecessary, but that some of it is. And that is the challenge before us, how to identify the some.

Mr. PICKLE. Dr. Roper, I must repeat that when you simply make the statement we have increased costs but we cannot show that we have had improved quality of care, it is just a self-serving statement that really does not go to the heart of this problem, as I see it.

I think you have got legitimate recommendations in the four areas you mention and we ought to look at them to see what we can do. If there is over utilization, or over charging, we ought to do something about it.

I think your suggestions are generally good, but I also think that we ought to try not to be biased as we try to find a solution to this problem.

Chairman **Rostenkowski**. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

Somehow I sense, dangling out there in the discussion of this issue, the notion that if Congress wished to do so, it could easily keep this increase from taking effect. I think it therefore useful to explore what that would cost.

My understanding is that for every dollar per month that the part B premium would be reduced below the $24.80, the deficit would increase by roughly $400 million a year. Therefore, if the rate were left at the $22.80 or thereabouts, which we had earlier anticipated, the deficit would increase by about $800 million a year.

Is that approximately correct, Dr. Roper?

Dr. **Roper**. I think so, yes, sir.

The figure I have is that if, for example, the premium for this next year is set, not at $24.80, but at $18.13—the amount it would be if we increased the $17.90 by the Social Security COLA which is current law beginning in 1989—that there would be a cost of $1.9 billion. That is a difference of $6 in premium, which translates into $1.9 billion. So it is about $300 million per percent.

Your figure was $400 million. We are close.

Mr. **Gradison**. I think this is very useful information and helps put this increase into perspective, not only with regard to the part B premium, but some of the other increases and improvements in benefits which have been discussed by this committee before, related to catastrophic protection and to outpatient prescription drugs.

The big difference in the discussion about the new benefits as compared with previous times, is that there has been a tacit agreement that whatever increase took place for catastrophic insurance or for outpatient prescription drugs would be paid for by the elderly themselves.

Now there is disagreement about how to distribute that cost among the elderly. But in the past, for example, when Medicare was put on the books, the costs were borne, as they are today, by current workers and their employers, and not directly by the elderly after they have retired.

Therefore, runaway part B costs has a definite impact, or at least should, on how we react to proposals to increase and expand benefits. The reaction which we have been receiving from the elderly to this increase of $2 a month, in the part B premium above what was anticipated earlier, is a shadow of what we are likely to hear about the kind of increases which are being discussed, and indeed which this committee has recommended for catastrophic protection and for outpatient prescription drugs.

If you want to react to that, that would be fine, but I just want to make sure to make that point for the record.

Dr. **Roper**. I think you are right on target.

Mr. **Gradison**. Thank you, Mr. Chairman.

Mr. **Gregg**. Would the gentleman yield?

Mr. **Gradison**. If I have time, I would be happy to yield to the gentleman from New Hampshire.

Mr. **Gregg**. Could you follow up, Dr. Roper, on the premiums that would be applied under the catastrophic bill, with the drug benefit on a monthly increase basis?

Dr. **Roper**. Excuse me, I did not hear your question.

Mr. **Gregg**. I was asking Mr. Gradison if—I will ask you directly, since he yielded to me. Can you give us the monthly premium figures for the catastrophic bill as passed the House?

Dr. **Roper**. I surely can supply those. I do not have them with me. We will supply them for the record, if that is acceptable.

[The information follows:]

Our actuaries estimate that the House-passed catastrophic bill would increase the monthly part B premium by a total of $33 in 1989—$13 for the basic catastrophic benefit; $15 for the drug benefit; and $5 for the in-home respite care provision. These estimates assume that drug benefit and in-home respite care benefit would be fully financed through a premium.

Mr. **Gregg**. Thank you.

Mr. **Gradison**. Thank you, Mr. Chairman.

Chairman **Rostenkowski**. Mr. Stark.

Mr. **Stark**. Thank you, Mr. Chairman.

Thank you, Dr. Roper. I would like to get into the issues in your testimony, but I have just a couple of questions first.

Basically, next year, if present law holds, the increases in the part B premium will be limited to the amount of the COLA adjustment. Is that not correct?

Dr. **Roper**. To the same percentage as the COLA, yes, sir.

Mr. **Stark**. So if the cost of living adjustment to Social Security next year is 2 percent, the most we could raise Part B next year is 2 percent?

Dr. **Roper**. That is right.

Mr. **Stark**. The balance would have to come out of general revenues?

Dr. **Roper**. That is right.

Mr. **Stark**. And we would have some budget pressures because of the increase in the deficit.

Do we have any discretion that—about 25 percent of the increase is catch up, right?

Dr. **Roper**. 22 percent.

Mr. **Stark**. Do we have any discretion on that?

Dr. **Roper**. You mean could there be a lower premium?

Mr. **Stark**. Let us say we have to raise $2 to pay back the trust fund, in round figures. What if we made that 60 cents a year for four years? On the theory that we can only go up a couple of percent next year on the COLA, we would end up replenishing the trust fund. But instead of raising everybody up $4 in one year, we would go up $2.60 and then somewhat less in the out years.

Is that technically possible?

Dr. **Roper**. It is technically possible, but I would have to tell you that I do not think it is prudent to do that.

Mr. **Stark**. I understand the problems that it could cause from the budget and planning perspective. I just want to procedurally see if that is the only option that we have, under law, is it not?

Dr. **Roper**. Right.

Mr. Stark. In other words, approximately 80 percent of the increase is in law now. It will be limited in future years to the cost of living adjustment percentage on Social Security. So the only flexibility either the administration or the Congress has without changing the law is how we might catch up on the approximately 22 percent increase.

Is that the situation we are in?

Dr. Roper. The point I was getting to is that it is a judgment call as to what is a prudent balance to leave in the fund and we think we are, under reasonable assumptions, making a prudent judgment.

Mr. Stark. Thank you very much.

Over the past years, as you have indicated, we have focused on one other question. In your testimony you suggest that approximately 65 percent of the increase is due to payments to physicians. Is it fair to say that if we set aside the trust fund recapture, that 90 percent or more of all part B costs either go to physicians or are directed by physicians?

Dr. Roper. Physicians are the decisionmakers in the health care system.

Mr. Stark. So we are basically talking about how we pay physicians or how they charge us or the beneficiaries and what we might do to adjust those payments and charges. Is that not really the issue if we are talking about the long range growth in part B premiums?

Dr. Roper. Yes.

Mr. Stark. We focused on price reforms over the past few years, relative value scales, and limiting payments. We have tried DRGs for the RAPs. You are more familiar than I am, perhaps, with all of this.

Should we change our strategy now? I do not recall that our committee has ever dealt with the volume issue. Should we be looking purely at volume and the review of procedures?

Dr. Roper. We feel very strongly that attention needs to be focused on the volume. I think up until now, as you were saying, most everybody has been spending time and effort on limiting fees. But over time, not just this year, but over the last decade or decade and a half, at least half of the increase in costs has been to an increase in volume of services and intensity, nonprice issues, if you will.

That deserves a lot of attention, a lot of focus.

Mr. Stark. We are going to hear very much today about an article that was published in the American Medical Association newspaper. The article was about a study that Dr. Peter McMenamin who works for you is preparing. The article asserted that the study this doctor is doing showed that physicians "are not gaming the system."

I have that in quotation marks because I do not imply, in gaming the system, a moral judgment. I imply that if a person has a choice between checking two blocks on a form, they are going to check the one that gives them the most money. It is legal and it is not, in many instances, it is a matter of choice.

So gaming is something that I think that anybody in a financial pursuit does, and I use it not in a pejorative sense. Could you comment on the McMenamin study and your feelings on its use? The study will come up later today, and I would like to have your thoughts about it.

Dr. ROPER. The study by Peter McMenamin is a study that looks at physician behavior during the fee freeze that was in place during fiscal years 1984, 1985, and part of 1986. The article, as you mentioned, was in the American Medical News and it discussed preliminary results from a draft interim report to HHS, which funded the study by Dr. McMenamin and others.

What the study, or at least the summary of the study, purported to say was that in the six States that were part of this study, there was not found to be, during the fee freeze, an upcoding of physician services.

Let me take a minute to explain what all that means. First of all, they studied six States, two of which were the Dakotas. By that I mean to imply this was not a broad study of the entire Nation. I do not mean to bash North and South Dakota. What was studied in this period was the type of services that physicians rendered during the freeze and whether or not there was any generalized behavior of the sort you describe, that is, charging for a complicated visit when it was really an intermediate visit or an intermediate when it was really a simple visit, that sort of thing.

They found that there was not much of this behavior was going on. There was some. And some, even one or two percent, when it is translated into 500,000 physicians in a program serving 30 million beneficiaries, is hundreds of millions of dollars.

So the fact that there was only some, I think, is important to not brush aside.

The main point, I think, about the McMenamin study is, that it deals only with the issue of upcoding, not the general increase in numbers of units of service. We do know that in this period of the freeze, more office visits were done, more outpatient surgery was done, more service was rendered by physicians. And so the fact that one explanation has been offered, that is, upcoding, and this was not found to be the major explainer of the increase in physician spending during the period of the fee freeze, to me does not do away with the central problem that we face.

And I come back to that central problem. In the most recent 12 months, physician spending—excuse me, part B spending has gone up 20 percent. The money is going somewhere, and that is the problem.

Mr. STARK. I have just one final question. We will hear justification or explanations for this rapid 20 percent increase, and I will list four of them here and just ask if you might comment quickly on them.

We may hear that the shift of care to the outpatient setting is a result of the prospective payment system, and that is causing an increase in physicians fees. We may hear that an older, aging population of Medicare beneficiaries is increasing severity, intensity and so forth and causing the increase in physician fees.

We may hear that beneficiaries induce demand. Then we may hear that there are unmet health care needs in the population and that all of those are the explanations for this increase. I wonder if you could just briefly comment on those explanations.

Dr. **Roper**. Sure. Let me, before I begin with each of those, make a central point that I want to be understood. I am not saying that all of this increase in part B outlays is unnecessary or that we ought to cut it all out. I think the bulk of it is services that go to benefit Medicare beneficiaries. It is to be applauded. My colleagues, the physicians of America, are doing well by their patients, treating them appropriately.

However, the point I strain to disagree with is that we should simply say that there are easy explanations, and that therefore there is not a problem and we ought to go on and deal with something else. To get to your hypotheses.

One was that prospective payment has shifted services from the hospital to outpatient setting, and therefore you would expect outpatient spending to go up. Understand that what we are talking about is physician fees and physician fees. So physicians who did surgery in the hospital were paid a fee, a part B fee. Physicians who are now doing surgery as an outpatient are paid a fee, a part B fee. And the fact that costs are rising so much is not simply explained by the fact that the service is being done as an outpatient instead of as an inpatient.

Now the more complicated part of that argument is, there are some things contained in the part B payments that are facility payments. That is to say, things that probably the hospital would have covered if it had been done in a hospital, and now part B is covering if it is done as an outpatient. That is real, and it can be measured, and we believe it is a very small explainer of this increase in part B outlays.

Second argument, if I am remembering it right, was aging of the population. Two percent of the increase is due to more people over 65, more Medicare beneficiaries. In addition to that, the whole cohort of the aged is older, and therefore, presumably more in need of health care services. But that is, again, only a very tiny explainer of this increase in health care spending.

A third is enhanced demand for services by Medicare beneficiaries. And that is often encouraged, as I said in my testimony, by the fact that the deductible is less of an obstacle to incurring part B payments, and therefore, people are demanding more services. Again, we do not believe that that is a major explainer of the increase in outlays.

And the fourth is that there is, or has been, a pent up demand for services—people are simply exercising their legitimate right to get Medicare services, and they are better off for it, and we ought to be proud of that fact. Some of that is the case. But again, in looking at comparing rates of utilization of various kinds of medical service across the country, we do not believe that that fully explains, by any stretch, this overall phenomenon.

Mr. **Stark**. Thank you.

Chairman **Rostenkowski**. Mr. Jenkins.

Mr. **Jenkins**. Thank you, Mr. Chairman. I want to follow up on that because I still do not get the 20-percent increase. As I understand what has happened with physician's fees, they have generally been frozen, have they not?

Dr. **Roper**. There was a freeze that began July 1 of 1984, and ended 22 months later for participating physicians and 30 months later for nonparticipating physicians.

Mr. **Jenkins**. The tremendous increase that we see in Part B cannot then generally be attributable to a tremendous increase in the per unit care cost to the physician. That is, the physician is reimbursed; is that correct?

Dr. **Roper**. The figure that I am giving you is a 20 percent increase in outlays over the most recent 12-month period. Of that 20 percent, about 6.5 percent is explained by the increase in physician's fees, that is, prices. Another 9-plus percent is increase in utilization, intensity, et cetera. And about 2 percent is the population.

Mr. **Jenkins**. Of the 20-percent increase, are we talking about a total of roughly 6 percent that is attributable to the increase in physician's fees?

Dr. **Roper**. 6.5 percent, yes, sir; 6.8 percent, actually. It is not additive, you have to multiply those figures.

Mr. **Jenkins**. Even though there has been a freeze, that has been the normal increase that is allowable?

Dr. **Roper**. It is woefully complicated, but here goes. Beginning when the fee freeze ended—and it ended May 1, 1986 for participating doctors, and it ended January 1, 1987 for nonparticipating doctors, fees were allowed to increase. The Medicare Economic Index constrained the amount by which prevailing fees were increased.

But the point I was trying to make in my testimony, let me elaborate on now. That is, many doctors—more than half of all doctors in America's, actual and customary charges were below this limit. And so, once the fee freeze went away, they were able to increase their fees by a substantial amount. That is not to say that was good or bad, that just happened.

Mr. **Jenkins**. That is what I want to ask. They had been held below the limit because of the freeze in previous years?

Dr. **Roper**. Yes, sir.

Mr. **Jenkins**. And therefore, is it your testimony that there is anything wrong with——

Dr. **Roper**. Not a bit.

Mr. **Jenkins** [continuing]. When the freeze was lifted, they were below the customary charge?

Dr. **Roper**. Not a bit. I am not——

Mr. **Jenkins**. There have been a lot of press reports and a lot of statements made. I am not on the subcommittee, but is the villain the physician that is suddenly increasing his fees in the last year that amounts to this 20 percent increase?

Dr. **Roper**. There is a longstanding increase in the part B outlays, much of which is either physician fees or is generated by physician's decisions. Over time, the increase in prices for physician services and the increase in the utilization of those services, both contribute to that growth in spending. And the point that I am straining to make clearly is that while prices are a part of this, utilization is clearly every bit as much a part and probably in most years more.

A question that I think you all will be asked to discuss is, are you going to allow in the future—next year, for example, increase in fees of the magnitude that has happened in the past year. If you decide no, we are not going to allow that and you freeze fees or you somehow constrain fees again, that does not deal with the other part of the equation, the utilization of services.

And the point again that I am making is, getting at what is appropriate utilization of services and how to influence decisions on that is altogether difficult.

Mr. **Jenkins**. Have the physician's fees gone up more than what we have permitted under the law?

Dr. **Roper**. No, sir. We have no evidence that physicians in any generalized way have broken the law or have abused the Medicare program. I am not alleging that at all. I do think that physicians in general have done well in the Medicare program. Physician income and more rapidly than CPI, and more rapidly than other professions in the economy.

Mr. **Jenkins**. Is that because of increased volume or because of the increase in their fees?

Dr. **Roper**. Both.

Mr. **Jenkins**. Are their fees too high or are they seeing too many patients? Or is it both?

Dr. **Roper**. Both price and volume have led to increased payout by the Medicare program; looked at the other way, increased income to physicians.

Mr. **Jenkins**. My time is up, thank you, Mr. Chairman.

Chairman **Rostenkowski**. Mr. Chandler.

Mr. **Chandler**. Thank you, Mr. Chairman. If I could follow along the questions of the gentleman from Georgia, I think that that is important. As you were talking, you admitted that it is hard to tell exactly what this increase utilization all means. But you did say that it does not look as if hospitalization is, for the elderly, increasing at the rate of utilization of physician services; is that correct?

Dr. **Roper**. I believe the figures, Congressman, are that the rate of increase for part A, the hospital part of Medicare is about 5 percent this past year, compared with the 20 percent, roughly, we have seen in part B. But again, we have given strong incentives to the hospital industry through limiting the program in the prospective payment system, so lower increases are to be expected in part A.

Mr. **Chandler**. One possible explanation of the increase in Medicare utilization is that a few years ago you did not have the technology for the kinds of sophisticated procedures with cataract and other eye operations, heart and so forth. But what you just said would suggest that it is not those sophisticated procedures that are accounting for the increase in physician payments, but rather something that is occurring at the doctor's office. Does that follow?

Dr. **Roper**. I am not sure I understood your question.

Mr. **Chandler**. If they are not going to the hospital and physician's are not charging for their services at the hospital, they must be charging for their services at the office.

Dr. **Roper**. Yes, sir.

Mr. **Chandler**. Then what kind of services are being offered at the office at a greater rate than they were before?

Dr. **Roper**. Many things are being done in offices or outpatient departments that formerly were done in the hospital, and that is to be applauded. We seek to diminish the number of unnecessary admissions in the Medicare program, admissions to hospital. That is one of the principles of the review done by the peer review organizations of hospitalizations.

Mr. **Chandler**. Is there any evidence that the increase in office visits are for nonessential services, people with a cold or flu who could just as well treat themselves or get some advice by phone?

Dr. **Roper**. Let me say again that I believe that some of the services are unnecessary. Now it is altogether difficult to quantify that sort of statement. The reason I believe that some of it is unnecessary is based on, again, two things. One, the variation—the rather striking variation, in the amount of services that are rendered in various parts of the country without any corresponding improvement or worsening of the health status of those populations that would correlate with the amount of doctor or hospital services that they received.

The other thing that I would point to as my reason for asserting that some of it is unnecessary is a body of research evidence that has looked carefully at individual cases, individual patients and has said, looking back over time, it really was not necessary to do this. That patient did not need that service, or it could have been done in a less costly fashion. And I cited one example from the Rand Corp. study of coronary artery bypass grafting. There are a number of others I could cite.

The fact that we have new technology is, in the first instance, to be applauded and rejoiced about. People are better off. They are healthier because of that. But it does not necessarily follow then that every patient ought to get all the new technology.

Mr. **Chandler**. One final question, and again the gentleman from Georgia was along this line. If we, working with the administration are to respond to try to bring down this growth, probably the physician fee, suppression of that is going to be less effective than if we work on the utilization side of the equation.

Dr. **Roper**. I think that utilization needs to be focused on very much so, and that is what I have stressed. You are right, sir.

If I could just say again, we believe that these sorts of cumbersome decisions about how much to pay all doctors in America are a strain. Further decisions, that I would be charged with making, about whether somebody in the State of Washington really deserved that procedure, are those kinds of decisions we make with great difficulty. Frankly, we do not make them very well at all.

And what we are trying to do in this idea of capitation, private health plans, is allow Medicare beneficiaries to enroll in private plans. We would pay a lump sum per year, and then let the plans at the local level, out there in Washington, make decisions about how much to pay doctors and whether or not to provide a given service. And I urge you to look carefully at that and give us the running room we need to make progress in this area.

Mr. **Chandler**. Thank you, Mr. Chairman.

Chairman **Rostenkowski**. Mr. Coyne.

Mr. **Coyne**. I have no questions.

Chairman **Rostenkowski**. Mr. Rangel.

Mr. **Rangel**. No questions.

Chairman **Rostenkowski**. Mr. Levin.

Mr. **Levin**. Thank you, Mr. Chairman. Let us spend a little more time on the issue of volume of services because it is not the entire issue, but it is one of the nubs. It seems to me we want to both make sure that we do not pull our punches but also avoid scapegoating.

So let me zero in on this. In your testimony, on page 17 at the bottom you say, "past experience tells us that physicians will respond to price reductions or payment redistributions that will occur under an RVS plan by increasing volume." And you said earlier that part of this problem is unnecessary services. It is hard to quantify but it is somewhat substantial.

We are going to hear testimony later from the AMA which has a different emphasis. And it says on page 6, "most of the increase is attributable directly to Medicare beneficiaries receiving necessary and valuable services for their well-being."

And then we are going to hear from Dr. Eisenberg, and his testimony is that "some of the increase in services undoubtedly reflects an increase in services that do not help patients significantly."

So the committee and Congress it seems to me, face this issue, that according to HCFA and according to the Physician Payment Review Commission, there is some significant ingredient that is involved in this unexpected increase that reflects unnecessary services. The expansion of services, according to your own testimony, is due to some extent because we have clamped down on what we pay for services.

Now we need your help on how we get at this. I mean, the frustrating part of it, as Dr. Eisenberg describes, is that we do not seem to be ready. There are lots of studies but no proposals emanating from his testimony.

And in your testimony, you describe the problem but it is not clear what you propose to get at this issue. Sometimes you seem to respond by fuzzing the factor. But your testimony is rather clear. I found your statement about response by expanding services, by increasing volume—I mean, that is clear English.

So tell us a little more. I mean, what do we do now? Wait for studies? Scratch our head? What do we do?

Dr. **Roper**. I would ask you to do several things. And let me try to respond to the many points that you made. First of all, the statement about if there are limits on prices, it is to be expected that normal behavior—not venal by any means—but normal behavior of individuals will be to exercise the degree of freedom that they do have, which is to increase, enhance volume of services.

Mr. **Levin**. It is not venal, but it is inappropriate and we should not pay for it.

Dr. **Roper**. My stipulation on that point is that some of it is inappropriate. And you said that my response was fuzzy on some points, and this is one of the fuzziest because it is—the amount of unnecessary utilization is very difficult to get it. And bear with me a minute.

Mr. **Levin**. You run this program. Just give us some guess.

Dr. **Roper**. I do not have a figure for you, Congressman.

Mr. **Levin**. Is it substantial?

Dr. Roper. It is enough to be seriously concerned about, and it is enough to call for our action and your action to deal with the question of utilization.

Mr. Levin. So what do we do now?

Dr. Roper. What you do now, first of all, is allow us to do what we think is the best solution to this problem. And that is capitation.

Mr. Levin. How much would that save? If we gave you all you wanted now, and we have not, by how much more or less would the premium increase?

Dr. Roper. I do not have a projection of that sort.

Mr. Levin. You have quantified everything else.

Dr. Roper. What that would say is that if we are able to enroll many more Medicare beneficiaries in capitated plans, over time it would constrain program prices, or cause spending restraint. But the magnitude of that is impossible for me to give you.

Mr. Levin. So what else?

Dr. Roper. But what it would give you—and let me be careful on this point—is the assurance that people at the local level in those private plans, like Blue Care in Michigan, were making decisions on whether or not a patient needed a given service instead of me, or one of the people that work for me here in Washington or Baltimore, making those decisions based on national considerations.

Mr. Levin. I understand that. And that is more long term than it is for 1988.

Dr. Roper. It is medium term.

Mr. Levin. What else? What do we do vis-a-vis 1988?

Dr. Roper. What you do now is allow us to do more intensive review of these individual cases to determine medical necessity. That means looking over the shoulders of doctors and second-guessing their decisions and denying payments for some of the cases.

And then understand that that is going to trigger constituent mail to you. And you allow us the freedom to do that kind of thing under your oversight without getting all over my back every time somebody says, Medicare has made a decision that I do not like.

Mr. Levin. We understand that. You propose a 40 percent increase. Why 40, not 80?

Mr. Russo [presiding]. The gentleman's time has expired.

Dr. Roper. Limited budget.

Mr. Russo. Mr. Andrews.

[No response.]

Mr. Russo. Let me just say, Dr. Roper—because I am next on the list—there is no question that you have a difficult job and that your job is usually to give us some bad news about changes you have to make. It is a good thing you do not run for re-election because if you ever made these proposals as part of your platform you probably would not succeed, so it is a good thing you are insulated from that problem.

You stated that in dealing with physician fees that you talked about setting up averages, but then let local areas decide what they should and should not do. How would that work?

Dr. Roper. The way it does work now is about 160 private health plans across the country are under contract to Medicare. We pay those plans a fixed amount of money each month and they enroll

Medicare beneficiaries who choose to enroll. And then they hire doctors and make arrangements with hospitals, and they deliver the health care services given the fixed amount of money that we give them. And that is much less oversight by us over how much to pay an individual——

Mr. **Russo**. But you still set the overall fee.

Dr. **Roper**. Yes.

Mr. **Russo**. It cannot be any higher—it does not take into consideration the regional differences.

Dr. **Roper**. It does. It is a formula that is calculated on a county by county basis that takes into—figures in how much the variation is across the country.

Mr. **Russo**. On what did you base that decision on how to set these fees?

Dr. **Roper**. The calculation is based on how much is currently being spent in Chicago, or wherever in the regular Medicare program, for the care of similar patients.

Mr. **Russo**. Is that the same basis on which you do prospective payment for hospitals also?

Dr. **Roper**. It is similar in that there is a calculation based on regional variation, but it is a much better formula, a much better projection.

Mr. **Russo**. Because I have a running battle with HCFA.

Dr. **Roper**. I know you do. That is why I am straining——

Mr. **Russo**. I do not quite understand how you arrive at these different averages and regional figures, when in 1983 as part of an amendment that I had adopted, we requested a study to be done which was supposed to be completed on September 1, 1984, so we could have a better idea of how we can cope with prospective payment and why certain regions of the country were disadvantaged.

And yet, we do not have that study, but you are making decisions based on averages, what the average fee is, what is happening in Chicago, and what is happening in Cooke County and DuPage County and Lake County. And yet, you do not have this study back yet. Have you asked for the study to be done?

Dr. **Roper**. Sure. The study is almost completed.

Mr. **Russo**. But you are actually arriving at all these decisions before you even have the study.

Dr. **Roper**. Sure.

Mr. **Russo** [continuing]. Making regional decisions without the study. I just hope that the Harvard group when it does your study for RVS's will be a little more prompt in helping you make decisions than you have been in helping us make decisions on the regional problems, because every year I have to fight in reconciliation that I prefer not to fight, if I had the data and information that we requested in September of 1983.

It is a little bit disconcerting for me to sit up here, requesting all these studies so you can do a better job. I am trying to do an efficient job, and I cannot get you and your agency to conclude the study I need.

The last time I was here, I had a discussion with Mr. Daub, who was going to help me get the study. But so far, not I nor Mr. Daub can get you to do the study quick enough.

What will it take to get the study so next time I can have the facts and figures in front of me, so when I argue with my good friends from the South and the West, who are making an absolute killing on the Midwest, at least I can show them some reasonable information.

Am I going to have to go through this again, and then one day you will be gone and there will be another doctor sitting in front of me, head of HCFA, and he will say, we are working on it, and we still will not get it? Because I have been getting this song and dance since September 1, 1984.

Mr. **Daub**. Would the gentleman yield? I just want an answer. Where is the report? Where is it? We asked you a year ago about it, Dr. Roper. Where is the report?

Dr. **Roper**. It is no longer in the Health Care Financing Administration.

Mr. **Daub**. It is finished in your Department. Where is it now? Where is it, do you know?

Dr. **Roper**. We are working on it. It is in the Office of the Secretary.

Mr. **Daub**. How long has it been in the Office of the Secretary, if the gentleman will continue to yield?

Mr. **Russo**. I will yield. I am just enjoying this. [Laughter.]

Mr. **Daub**. Let us get it pinned down. I mean, if you have finished your work, has long has it been in the Secretary's office?

Dr. **Roper**. I would have to check. I would glad to supply that for you.

[The information follows:]

The report to Congress on urban-rural payment differentials in the prospective payment system was submitted to the Office of the Secretary in August, 1987. It has been revised and is now under review at the Executive Office of Management and Budget.

Mr. **Russo**. I think you know that, do you not? You know how long it has been?

Dr. **Roper**. [Shaking head negatively.]

Mr. **Russo**. You do not? It is not a major issue with——

Dr. **Roper**. As passionately as you are interested in this subject—and believe me, I would like to get it behind us—we have 30 or 40 reports that we are working on.

Mr. **Russo**. I know you are overloaded. But I mean, again, I think we have been reasonable here. It was mandated in 1983 to be reported on September 1 of 1984. This is already now close to October 1 of 1987. You know, we get criticized for being inefficient, but major decisions have been made over the last 3 years affecting a tremendous number of hospitals without this particular study.

And that is one reason I was going to ask you what your definition of averages is on page 18? When you talk about putting averages together, how do you arrive at that definition of averages?

What do you base averages on?

Dr. **Roper**. Under the bundled payment section?

Mr. **Russo**. Yes, bundled payments, right, and fixed price based on averages.

Dr. **Roper**. The same sort of methodology that we are talking about in PPS.

Mr. Russo. Obviously you have some kind of formula that you use and, for whatever reason, the formula does not work properly in certain regions of the country, but nothing has been done to try and correct it. I guess that is what disturbs me. I just want to make sure that we have that study within the next couple of months.

Can we possibly get it within the next couple of months?

Dr. Roper. It is surely my intention to do that, Congressman.

Mr. Russo. I would appreciate it. I am sorry to put you on the hot seat. I did not mean to do that, but it is not too often we get the opportunity.

One last thing that I would like to ask. I had a problem in my district a while ago where an individual physician was charging way below the norm. Say the norm was $45 and he was charging $10 per visit. He wanted to increase it to $20 and continue to collect for a year at $20.

He was penalized, or was giving to be penalized by HCFA, because he raised his price $10 and the person who was charging $45 the whole time did not have any problem whatsoever. Do you think that is fair?

Dr. Roper. No, it is not fair, but it is the law. It is the way the system works. The fee that we pay a doctor is the lowest of either the actual amount he charges for that patient, the customary amount that he charge and that is the $10 for that doctor, or the prevailing amount which is the amount that doctors like him in that area charge.

The fact that over time he habitually charged lower has come to be a real problem for him, and doctors all across America are facing that.

That points out the central inequities in this system that we currently have.

Mr. Russo. I want to help you try to correct it. I do not think you ought to penalize somebody who has been efficient. We ought to be giving those individuals incentives. It seems to me that when we raised, took the freeze off, we created an incentive for the physicians who were being efficient to raise their fee just to get even because all these years they had been penalized by being efficient.

I think it is the wrong way to go and I certainly hope there is something we can do, we can work out, that deals with this particular problem because I think it is unfair for those physicians who are doing an excellent job to be penalized for keeping their prices down.

Thank you. I look forward to obtaining the report and I certainly will send a copy to the gentleman from Nebraska as soon as I get it.

Mr. Gregg.

Mr. Gregg. Thank you.

Earlier, I asked you a question relative to Mr. Gradison's question, which was how much premiums would raise under the catastrophic bill as it passed the House. I have now been supplied with numbers. It appears that the basic premium under that bill, as projected by your Department, will increase $13 per month in 1989.

The additional premium put on, as a result of that bill, due to the drug benefit, will increase $15 per month in 1989 and the in home care respite language of that bill would add another $5 to the premium.

So under the House catastrophic bill, the projections from HCFA are that in 1989 the monthly premium increase will be $33. Here we are talking about a $2 increase. I think the Congress might want to call back that bill if we are going to have hearings on $2 for one day, maybe we should have hearings on $33 for 15 days and rehear the catastrophic bill.

I would like to concentrate a little bit the question of controlling what is driving the cost. I want to get back to the basic issue of what these costs represent because I think you went over them fairly quickly in your testimony.

As I understand it, under the present law, you are required to go to the 25 percent of costs for the year 1988, is that correct?

Dr. **Roper**. Yes, sir, that is correct.

Mr. **Gregg**. And that provision is scheduled to lapse, so that in 1989 the cost increase would be generated by the Cost of Living Index, is that correct?

Dr. **Roper**. That is correct.

Mr. **Gregg**. It would not be the medical cost of index, it would be the Social Security COLA?

Dr. **Roper**. The Social Security COLA.

Mr. **Gregg**. So it is really apples and oranges, as to what the cost increase will be relative to what the actual costs will be?

Dr. **Roper**. Yes.

Mr. **Gregg**. Your projection is that over a 3 or 4 year period, instead of being 25 percent of the actual costs, the seniors would then be paying about 17 percent?

Dr. **Roper**. By fiscal 1993, yes.

Mr. **Gregg**. By fiscal 1993, their contribution, through their premiums, to the cost of the program which they will be benefitting from, would be about 17 percent of the cost of that program?

Dr. **Roper**. Yes.

Mr. **Gregg**. So there will be 83 percent of that program that will not be covered by their premium?

Dr. **Roper**. That is right.

Mr. **Gregg**. Do you have a figure on how much that would be, that 83 percent, approximately in dollars?

Dr. **Roper**. We will get it for you. It would be 83 percent of what we are projecting outlays to be.

[The information follows:]

In Fiscal Year 1993, we estimate that $60.1 billion in general revenues will be required to finance the part B program.

Mr. **Gregg**. A ball park range?

Dr. **Roper**. Very substantial. Many, many billions of dollars.

Mr. **Gregg**. Many, many billions of dollars?

Dr. **Roper**. Yes.

Mr. **Gregg**. Tens of billions of dollars?

Dr. **Roper**. Yes.

Mr. **Gregg**. Who pays the tens of billions of dollars if the senior citizen who is benefitting from the program does not pay it?

Dr. **Roper**. It is either the taxpayers generally or the deficit.

Mr. **Gregg**. So, in reducing this premium from 25 percent down to 17 percent, we are not talking about reducing the cost of the program. We are just talking about shifting the cost of the program from one segment of the population to a different segment of the population, correct?

Dr. **Roper**. Yes.

Mr. **Gregg**. And we are talking about shifting tens of billions of dollars from one segment of the population to a different segment of the population?

Dr. **Roper**. Yes.

Mr. **Gregg**. So basically what we have is an inter-generational confrontation taking place, correct?

Dr. **Roper**. Yes.

Mr. **Gregg**. I am a little concerned about this word "some," on the issue of utilization. You said you really cannot define it any better and that ground has been gone over a little bit. But are there systems beyond which you have been talking about here that can control utilization?

In other words, could we put in a system where we shift from paying a flat premium which has basically no effect on utilization to going to a copayment situation so that there is an incentive to review whether the person incurs that expense and thus, hopefully, reduce utilization?

Dr. **Roper**. It is possible, Congressman, but at the present time there is a 20 percent coinsurance requirement for beneficiaries to pay when they use part B services after they pay a $75 deductible. The limitation on the utility of coinsurance as a restraint on utilization is reduced, though, because some 80-percent-plus of beneficiaries either are Medicaid eligible or purchase medigap insurance. So they do not have an out-of-pocket cost directly, themselves.

If you were to change the copayment amounts, I presume that you would see a change in the medigap insurance so I do not hold that out as a useful alternative for the future.

Mr. **Gregg**. You are just saying that the only way that we can control utilization is to control the provider's side. There is no way to control the demand side, that you folks can see.

Does that not sort of leave half the market place equation out of the issue?

Dr. **Roper**. I do not see further use of restraint on demand, as a hopeful alternative. What we seek to do, in the broadest terms, is give providers of service, in this case doctors, appropriate incentives for them to use their resources in a way that makes sense for them and their patients.

That is difficult and complex and tedious and all of that, but it will have an effect. After all, remember, that is what prospective payment has given hospitals, direct incentives to structure themselves more efficiently, to render service more efficiently. Everybody applauds that.

We are seeking to do that in the physician part of the Medicare program.

Mr. **Gregg**. I can understand. I do think, though, that you ought to be taking some imaginative thought to the demand side, too. If you do not address the demand side, I think you are really only getting at half the equation that is driving the utilization factor, myself.

Mr. **Stark** [presiding]. Before I recognize Mr. Pease, it is the intention of the Chair to recess at noon and reconvene at 1:15. Mr. Pease.

Mr. **Pease**. Thank you, Mr. Chairman, and thank you, Dr. Roper. I appreciate very much your offer and desire to work with the committee on a very difficult problem. From my work with you, I am impressed. I think your testimony this morning was excellent and I do not sense any ideological baggage in your attitude which would make it difficult for us to work with you. I certainly accept your invitation.

Have you given any thought at all, in solving this problem, or at least in dealing with the rather sharp increase for lower income or elderly people, the possibility of going to an income based premium for part B in general, as we have done in catastrophic health?

Dr. **Roper**. I have given some thought to it. We have not done any analysis to support that sort of proposal, but it is something I have given thought to, yes, sir.

Mr. **Pease**. It seems to me that we are very concerned, as we ought to be, about the impact of a large, $6 or $7 increase, on people who are on Social Security alone or who do not have a very high income and do not get very much of a COLA increase.

But in fact, there are a lot of senior citizens who are much better able to bear that than others. It occurs to me that an income based premium might be helpful in that regard.

Let me go on. You are not allowed, under the law, to make a midcourse correction is that right?

Dr. **Roper**. If we found that, for example, we had set the premium too low, we would have to come back to you, the Congress, in midyear and ask for statutory authority to change the premium midyear.

Mr. **Pease**. It would have to be statutory authority.

Is my understanding correct regarding physician fees, that if Congress had not frozen physician fees for 30 months running, the part B premium would have gone up faster and sooner than it did?

Dr. **Roper**. Yes, sir. The fee freeze did hold down outlays.

Mr. **Pease**. Would it be your recommendation that the rule requiring 25 percent of part B costs to be born by beneficiaries be continued beyond 1988?

Dr. **Roper**. Yes, sir. Strongly, for all the reasons that Congressman Gregg put forward a minute ago, I believe that is a prudent course to take. Further, we suggest that new beneficiaries be charged 35 percent of program costs.

Mr. **Pease**. The $75 deductible that you mentioned in your testimony as having been static, you say does not contribute very significantly to the increase in premium costs. Realizing that that is probably the case, would it not make some sense, nonetheless, to adjust that from year to year, based on the annual cost of living index?

Dr. **Roper**. Yes, sir and the President has, for several years running, recommended that the $75 deductible be indexed. I believe that is prudent and ought to be done.

Mr. Pease. In your testimony, you speculate on a lot of possible reasons for the increase in physician spending. You run through a whole litany of them and, in almost each case, you say it is difficult to pin it down. Is there some point at which we will be able to pin it down?

For example, if physician fees were frozen, does that mean that the physicians had a higher degree of utilization, justified or unjustified? What part of it is attributable to more sophisticated, and therefore more lifesaving, procedures that were not available before, and so on?

It is hard for us to make policy decisions unless you can give us the statistical backup for those decisions.

Dr. Roper. I understand your frustration, Congressman. I feel the same myself. If I could just take a minute, we are doing a number of studies that will yield better information in the short and medium term, but it is the nature of the practice of medicine that much of what is done by doctors is in a gray area.

Some of it is obviously necessary. On the other end of the spectrum, most people would say a few things that are done are obviously unnecessary. But it is in the gray, middle part of the spectrum, that the difficulty arises. I have laid out, in my testimony and my response to questions, some things that I think we can do to get at that.

But fundamentally, what I think we need to do is give physicians incentives and the health plans that manage those physicians incentives to constrain utilization rather than us making national decisions. We do that kind of thing poorly.

Mr. Pease. Thank you very much, Dr. Roper.

Mr. Stark. Mr. Dorgan.

Mr. Dorgan. Thank you, Mr. Chairman.

Dr. Roper, Congressman Pickle asked some questions about the timing of all this. You are aware that the administration does not like the catastrophic health insurance bill that was passed and this unexpected news of the part B premium increase does not help the effort to pass a catastrophic health insurance bill.

Congressman Pickle seemed to suggest, and I would agree with him, that this increase came out of the blue. I assume you were not sitting at a desk down there and just got hit over the head with a mallet one day and said well we have now had 11 months of analysis and on the 12th month we decided we are going to have this dramatic increase because of new numbers.

Can you respond to that area and the speculation that is going on?

Dr. Roper. Sure. I do not mean to make light of your question but it is what did I know and when did I know it. The premium is promulgated each September. By law it is required by September 30. We have a process within the Agency that does the analysis and the calculations and that yields from our actuaries a number that they suggest is the appropriate number.

I got that information from the actuaries in early September. We have spent the last few weeks going back over their numbers and asking a lot of the same questions that you all have asked me today and a lot of others, and come to feel that the recommendations of the actuaries are justifiable or justified. Therefore, we are today publishing that premium.

Mr. **Dorgan**. It was actually published earlier from somebody, although I think it was an unnamed source, was it not?

Dr. **Roper**. Unnamed source was that we were going to publish but publication is today.

Mr. **Dorgan**. Do you know what that source was?

Dr. **Roper**. Discussions that we had with staff on the Hill. Discussions that we had with others in the health care community, physician organizations and others. I do not know the particular source.

Mr. **Dorgan**. Were you upset with the way that was announced?

Dr. **Roper**. No, sir. I think that is the nature of policy making in Washington.

Mr. **Dorgan**. How long have you been here?

Let me ask you another question about physician's fees. We read, from time to time, analysis that suggests that there are many, many more operations performed than would need to be performed in this country which, I assume, if you believe that, leads to a substantial amount of money going to physicians that need not be expended by the Federal Government.

What is your impression of that whole area? Have you done some work in that area?

Dr. **Roper**. I have not personally done, but we have paid for researchers to do studies and I have noted some of that in earlier questions. I believe that some surgical procedures and other activities of physicians are unnecessary but it has to be looked at on a case by case basis and it is tedious.

Mr. **Dorgan**. Is there any empirical evidence on what percent of surgical procedures might be unnecessary?

Dr. **Roper**. One study that I mentioned is from the Rand Corp. Preliminary results on coronary artery bypass grafts found that in 30 percent of cases they reviewed, the procedure was questionable. That is, a maybe. And 14 percent were clearly inappropriate, not needed.

Mr. **Dorgan**. And that is just in one procedure.

Dr. **Roper**. One procedure, one study.

Mr. **Dorgan**. But I am talking now about——

Dr. **Roper**. The aggregate, no. I do not have that kind of number for you.

Mr. **Dorgan**. Have you and HCFA attempted to get that kind of analysis from anyone? Are studies underway? Have they been completed?

Dr. **Roper**. We are doing a lot of studies but they are focused on particular procedures and I do not think it is doable or even wise to try to come up with some global percentage that is unnecessary. That is such a sweeping statement.

Mr. **Dorgan**. But are there not press reports which occasionally suggest that some studies have indicated *x* percent of the surgeries are unnecessary. Are you saying that you do not have any information about that, except for this coronary study?

Dr. **Roper**. I think that is the sort of sweeping lay press that says studies have shown that, whatever. What I am trying to, at pain, to describe is that it is more complicated than that.

Mr. **Dorgan**. I understand that, but when a government spends tens of billions of dollars, as we spend on the Medicare system, the fact that it is complicated should not persuade us not to learn what it is.

Dr. **Roper**. And we are working to do that.

Mr. **Dorgan**. In the one procedure that you have cited, you indicated that about 30 percent of the surgeries were questionable and 15 percent of the surgeries were clearly unwarranted. If, in that procedure, there are questions about a third of the money that is expended would that not lead you to question whether you should not get some more empirical evidence about the whole array of operations?

Dr. **Roper**. Maybe I am quibbling, and let me be short. What I am saying is not that we ought to be doing these kind of studies, but I am saying I do not think we are going to yield finally an aggregate number for all doctor services in America. What we are going to end up with is for a specific kind of procedure, we think so much should be done, so much should not be done.

Then we have to multiply that by the hundreds of different things that physicians do.

Your question raised a point, if I could take a minute and respond to it. Let me be clear in saying that 14 percent of coronary artery bypass grafts were unnecessary. That does not mean that those people did not have occluded coronary arteries. What it means is they could have been treated medically rather than surgically and there is a cost attendant to such medical treatment.

So it is not as if the money spent on the surgery could just be wiped out and Medicare would have no expenditures.

Mr. **Dorgan**. I understand that. Surgery is, of course, a very expensive procedure, and I am just trying to understand if, as America's largest consumer of health care, there are studies underway that would tell you that in these areas you are spending money you should not have to spend, or surgeries are being performed that should not be performed.

I guess your answer is that——

Dr. **Roper**. Yes.

Mr. **Dorgan**. There are studies underway?

Dr. **Roper**. Yes.

Mr. **Dorgan**. Can you tell me who is conducting those studies? Is it internal?

Dr. **Roper**. The Rand Corp. is doing a series of studies for us under contract, looking at this particular area of physician practice patterns and the appropriateness of services. I would be glad to supply, for the record, the other contractors we have studies underway with.

Mr. **Dorgan**. Would you do that? I would be very interested to know how extensive this analysis is. As the largest consumer in this country, we in the Federal Government, through the Medicare system, need to know those things.

Dr. **Roper**. Surely.

[The information follows:]

HCFA has supported a large number of studies over the past 10 years that have looked at the area of physician practice patterns and the appropriateness of services. Recently completed studies conducted by Dr. John Wennberg at Dartmouth and a number of projects with Brandeis, University Hospital, Inc., Systemetrics and other contractors initially identified the wide variations in physician practices patterns and utilization of services in various geographic areas. Several studies are currently underway to further analyze the impact of these variations.

The Rand Corp. is conducting an in-depth study of three procedures to examine whether high-use rates reflect inappropriate overuse and whether low procedure rates reflect underuse.

The Rand Corp. is also conducting a study to develop nonintrusive measures that can be used to measure the appropriateness of care provided.

Several intramural studies are analyzing the impact of differential use of certain procedures, for example whether hospitals with more surgeries have better outcomes such as lower mortality rates or whether there are patterns of rehospitalization for specific procedures or patient characteristics.

Pilot projects with PROs are collecting clinical data on patient characteristics and treatment for six conditions; these data will be linked to patient outcomes to assess the effectiveness of the interventions.

Mr. **Dorgan**. One final comment, Mr. Chairman, if I might. I agree with the comment by Mr. Gradison earlier in the hearing about the size of this increase. I am sure Mr. Gradison would not want anyone to misunderstand that this increase is not sizable for a husband and wife on Medicare whose only income is Social Security and who face this kind of increase on a monthly basis.

I mean it can, in some specific cases, be a very substantial problem, if they do not have any money left for anything, to discover now they have to spend more money on this premium increase.

Mr. **Gradison**. Would the gentleman yield?

Mr. **Dorgan**. I would be happy to yield.

Mr. **Gradison**. I thank the gentleman for yielding. You are absolutely right. My point was that this increase, which has occasioned an outcry across America because it does hurt and it is so large, is very small in comparison with the additional increases which may lie ahead to finance catastrophic care and outpatient prescription drugs.

Who will hear those cries of outrage if these additional costs do prove unacceptable to the elderly public? We will. That is all I was trying to say.

I thank the gentleman for yielding.

Mr. **Dorgan**. And it is a valid point. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. **Stark**. Mr. Crane.

Mr. **Crane**. Thank you, Mr. Chairman. I want to congratulate Dr. Roper for his presentation.

One of the things that struck me, in looking at your testimony, was that spending projections for last year were too low. Were the spending projections made a decade ago reliable?

Dr. **Roper**. A year ago.

Mr. **Crane**. But I mean a decade ago. From the beginning of Medicare, and the real costs have tremendously exceeded the projections. On that basis, I am curious as to your confidence in the reliability of the projections you are making for the next 5 years.

Dr. **Roper**. We make annual projections with difficulty. We make long term projections poorly.

Mr. **Crane**. That seems to be the history, I think, of most of the programs that we create here. Let me ask a question similar to one posed by Mr. Gregg earlier.

When was the deductible set at $75 for part B?

Dr. **Roper**. Excuse me. When was it set at $75?

Mr. **Crane**. Yes.

Dr. **Roper**. 1982.

Mr. **Crane**. So Congress just periodically takes a look at the deductible?

Dr. **Roper**. We have requested that the Congress index the deductible. Whether the Congress has taken a look at it, I leave to you.

Mr. **Crane**. The reason I ask that is again, getting back to basic economics, it seems to me that without an indexed deductible you have built in an enormous incentive for overutilization. The fact of the matter is that we have an option of capriciously freezing physician's fees or various other payments that we are going to make. Such actions are characteristic of every government health care program in the world. Sooner or later they get around to that for political considerations only.

In the worst extremes, like in Great Britain, they end up rationing the service and providing inferior health care to their people.

But it seems to me that that is only one option. The other option is to try and ascertain what is a reasonable deductible but guarantee that it is indexed to prevent the excessive demand for services that Mr. Gregg was talking about. Do you share that view?

Dr. **Roper**. That it would be wise to index the deductible?

Mr. **Crane**. That it should have been indexed from the very beginning?

Dr. **Roper**. Yes, sir.

Mr. **Crane**. To the credit of the new catastrophic health care bill, it does have provisions for indexation with both the cost of prescription drugs as well as the catastrophic coverage. But turning to that bill, in terms of the estimated cost, Treasury says that with the premium rate plus the projected tax increases on senior citizens, by the year 2000 the program will be running a $20 billion deficit.

Does that correspond roughly to your estimates?

Dr. **Roper**. It has been a while since I looked at the catastrophic estimates, Congressman, but it sounds about right.

Mr. **Crane**. And that deficit is on top of the projection of the bankruptcy of the Medicare trust fund by the year 2002. Presumably this would accelerate that target date for bankruptcy?

Dr. **Roper**. Let me think clearly. The catastrophic program is financed largely through premium.

Mr. **Crane**. No, largely through tax increases.

Dr. **Roper**. Well, tax increases, but they are not payroll taxes that go into the Medicare part A trust fund, so I do not think it would.

Mr. **Crane**. So it would not affect the pending bankruptcy of the Medicare trust fund?

Dr. **Roper**. No, sir.

Mr. **Crane**. Unless we made some adaptation to dip into that if we thought there was a surplus.

Let me ask you one final question, and it has to do with this contemplated catastrophic bill. I raised the question, when we had markup, as to the number of AIDS victims under age 65 who would qualify for the drug benefit through disability. With AZT costs running about $1,000 a month, AIDS victims would meet their prescription drug deductible in 2 weeks and then would be home free.

In contrast, only 17 percent of seniors would reach that deductible threshold of $500 a year. What this means is that the over-65 crowd would be picking up the cost of younger AIDS patients. Have you figured yet as to the size of the under-65 population that would be eligible for the drug benefit and have you made any projections as to the cost of this benefit? Dr. Bowen tells us it is going to double every year for the remaining years of the century.

Dr. **Roper**. No, Congressman, we do not and the reason we do not is we cannot know yet the actual impact of AZT and drugs like it. With such a new treatment, we do not have experience with which to project how many people are going to survive beyond the 24-month waiting period.

Mr. **Crane**. We have got some figures out which indicate that it may be a small percentage. The figure suggests maybe no more than 20 percent.

But on the other hand, without knowing those potential looming costs, and again looking at projections which you admitted are made with difficulty, I just wonder why there would be resistance to prohibiting 65 year olds from having to fund the prescription drug costs for the people under 65. It just strikes me as a fundamental injustice to put that burden on the senior citizen.

Dr. **Roper**. I think the fundamental principle that I would maintain is that it is unwise to make diagnosis-specific decisions in the Medicare program. And if I am following you, the effect of this is to say that for one class of patients their premium would be set a different way.

Mr. **Crane**. I am simply arguing the inequity of a program——

Dr. **Roper**. I take your point.

Mr. **Crane** [continuing]. Set up to take care of people 65 and older. We are going to have them pay for the program, and in doing so are opening up a potential Pandora's box of excessive liabilities that the 65 and older crowd are going to have to assume. And when we do not have those answers, it seems to me imprudent to proceed without some kind of safeguard. If we want to take care of the under 65's, fine, develop a way for doing that, but do not put the burden on the 65 and older.

Thank you, Dr. Roper.

Mr. **Donnelly** [presiding]. Dr. Roper, it is nice to see you, although I cannot say that I am surprised to see you on this issue, considering the policy decisions that this committee has made over the course of the last few years regarding cost containment recommendations, both from the administration, and from individual members of this committee, recommendations on limiting out-of-pocket expenses for the elderly. Just decisions made during my experience as a member of the Health Subcommittee made this hearing inevitable.

My good friend from Michigan said during his questioning of you: "Dr. Roper, you run the system." And I would disagree with that somewhat.

Dr. **Roper**. We have got a large——

Mr. **Donnelly**. I am afraid one of the problems around this place is that we run the system, and that you do not run the system.

And let me embellish that a little bit by asking a couple of questions.

You make four—you call them conceptual recommendations for controlling costs. One is limiting payment fees. What authority do you have now under the law to limit payment fees?

Dr. Roper. We have got authority to, on a procedure-by-procedure basis, go through a rulemaking and judge that a particular service is excessively priced and lower the price we pay for that. We do not have general authority to freeze fees or whatever.

Mr. Donnelly. Who has that authority, Doctor?

Dr. Roper. The Congress.

Mr. Donnelly. The Congress. More specifically, this committee, correct?

Dr. Roper. [Nodding affirmatively.]

Mr. Donnelly. You also make a recommendation for bundling services and paying a fixed price on average. Do you have authority to do that now?

Dr. Roper. No, sir.

Mr. Donnelly. Who has that authority, Doctor?

Dr. Roper. The Congress could confer that authority on us.

Mr. Donnelly. I think you are getting the point that I am making. I could not help but be struck by the irony of this hearing when I walked into the room with the TV cameras and the crowds and the politicians expressing their outrage and their anger and their astonishment at this increase in the premium. But over the course of the last few years, if these people had not rejected amendment after amendment or proposal after proposal, that would have, in fact, reduced this increase or made this increase not necessary, we all would not have to be here today.

Let me ask you more specifically about this: the administration made a recommendation to include radiologists, anesthesiologists and pathologists under the DRG system. What happened to that recommendation, Doctor?

Dr. Roper. Before this committee, I believe it lost in subcommittee. Maybe the full committee voted it down.

Mr. Donnelly. Had it been adopted, what would that have saved the trust fund?

Dr. Roper. We had estimated a $10 million savings in fiscal 1988, and further savings in the outyears.

Mr. Donnelly. Do you think we ought to include all physician services under a DRG system?

Dr. Roper. No, sir.

Mr. Donnelly. Why not?

Dr. Roper. I think the complexity of the averaging process that your colleague from Illinois was after me on makes it very difficult, if not impossible, to construct a DRG system for doctors.

Mr. Donnelly. Would you like total authority to set payment fees without having to come to the Congress?

Dr. Roper. Sure. [Laughter.]

Mr. Donnelly. Would you like total authority to make policy decisions like bundling services without having to come to the Congress?

Dr. Roper. Sure. And that is not a flip answer. If I could take a minute.

Mr. **Donnelly**. Please do.

Dr. **Roper**. The Congress has, in each of the reconciliation bills the last several years, dealt with the issue of physician payment in very complex ways. And I will attribute the best of motives to the Congress, but I want to tell you that the consequence of that has been to make our job extraordinarily complex.

Just for one example, setting limits on the amount that a doctor actually can charge, the so-called MAAC limits—well-intentioned, I am sure—has been woefully complex. And guess who gets the letters in response to that. It is the Medicare program.

And my plea to you basically, in response to this problem now, is that it is not simply enough to say there ought to be a law. And I would urge that you either give us general authority, which I took to be the thrust of your question, or be real thoughtful about what you legislate because there are likely to be further problems in the complexity that you give us.

Mr. **Donnelly**. The point that I am attempting to make, is that I think that it is absolutely idiotic for this committee or any committee of the Congress to be setting specific fees for physician services. For example, the recommendation on cataract surgery; an overpriced procedure. Medicare was paying substantially more than a private insurer. We went through World War III on this committee to set that fee.

Dr. **Roper**. We went through World War II and were about to reduce the payment when the Congress intervened, and you are right.

Mr. **Donnelly**. And it seems to me that until we have a basic rethinking of the role of the Congress, we are going to continue, because of the pressures placed upon the Congress itself or individual Members. I mean, there are no TV cameras here, there are no people here when those decisions are made. But the halls are filled with the lobbyists for the various interests who will suffer financial damages by the decisions of the individuals on this committee.

And I think that until we relook at your role and our role and how those roles interchange, we are going to be continually having you up here every year, expressing our astonishment and outrage at these increased premiums.

Mr. **Levin**. Will the gentleman yield?

Mr. **Donnelly**. I would be more than happy to yield.

Mr. **Levin**. Just a quick question. Did you need authority from us to reduce fees for cataract surgery?

Dr. **Roper**. No, sir, we did not. We were proceeding to do that, and the Congress chose to limit the cut to a smaller amount that we were proposing—what we were doing on our own.

Mr. **Donnelly**. I just have one quick final question, and it is: the increase in physician fees this year was 18 percent. You estimated that it would be 6 percent. It turned out to be 18 percent. You are estimating next year that it will be 11 percent.

Dr. **Roper**. 13, I thought, but anyhow.

Mr. **Donnelly**. Is it 13?

Dr. **Roper**. Something like that.

Mr. **Donnelly**. I mean, if we were so far off last year, I guess the question is, what sort of confidence do we have that it be 13 and not be triple, 36, as it tripled in 1987 causing a commensurate increase in the part B premium?

Dr. **Roper**. I take your point. We believe that we are making a prudent estimate for next year. The reason that this year had such an increase was that the freeze came off.

[The following was subsequently received:]

Our estimates for next year assume an 11 percent increase in physician reasonable charges per enrollee and a 13.9 percent increase total part B expenditures per enrollee.

Mr. **Donnelly**. Thank you, Doctor. We will see you next year on the same subject again, I am sure. Thank you very much.

The committee is very honored and pleased to have the distinguished chairman of the Rules Committee, Congressman Claude Pepper, appear before us.

Mr. **Gradison**. Mr. Chairman?

Mr. **Donnelly**. Mr. Gradison.

Mr. **Gradison**. Mr. Chairman, I understand that the following witness, our colleague from the committee, Congressman Daub of Nebraska will not be appearing in person to present his testimony. Therefore, Mr. Chairman, I would ask unanimous consent that the prepared statement of Congressman Daub be included in the record.

Mr. **Donnelly**. Without objection.

Mr. **Gradison**. Thank you.

[The statement of Mr. Daub follows:]

STATEMENT OF HON. HAL DAUB, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

INCREASES IN MEDICARE PART B PREMIUMS

Mister Chairman, I was shocked when I learned that the Department of Health and Human Services will be forced to raise the Medicare part B premium from $17.90 to $24.80 for fiscal year 1988—A 38.5% increase. And perhaps what troubled me even more was the premature reaction of the majority leadership of our Health Subcommittee, who immediately blamed physicians and accused them of taking advantage of the Treasury.

Certainly, I agree that part B expenditures are growing at an alarming rate. But before we start placing blame with doctors and their manner of treating the Medicare program's beneficiaries, we must first consider the fact that we have very little data from which we can precisely determine the reasons for this explosion in Medicare's part B.

There are those who allege that the premium rise is largely attributable to doctors who abuse the system—doctors who schedule unnecessary office visits, order unnecessary tests, or even, some will claim, perform unnecessary and "overpriced" procedures.

But what these critics often fail to consider is that a primary reason for more office visits, for more tests, for the more frequent performance of more expensive procedures, are the profoundly dramatic leaps in the past several years in the quality and technology of medicine. Today, for instance, cardiac treatment methods undreamed of ten years ago are regularly practiced with efficiency, consistency, and safety. However, these advanced treatments demand increased observation of the patient, more technical and time-consuming tests, and admittedly expensive and technologically advanced equipment.

In short, the cost of health care will rise as its quality rises. But are the benefits not worth the dollars paid to the providers? Lives which would have ended a few short years ago are being saved. And if in order to stay alive a medicare beneficiary must visit his doctor more often, undergo more tests, and be the subject of new and more elaborate procedures—all because modern medicine has more to offer him—then so be it.

Still, I of course, realize that we must determine how to control runaway costs. But accurate and reliable solutions must be based upon accurate and reliable information, something we simply do not have at this point.

In the Medicare years 1973 to 1983, we experienced what amounted to reasonably predictable increases in the cost of our health care program. The increases were often considered high, but then so was inflation and, again, the increases in medical technology and quality.

But in the past few years, between 1983 and 1987, the increases in part B premiums have been much more erratic, and it has been difficult to discern a pattern. The unpredictability of the expenditure rises is demonstrated by the fact that in 1984 we overestimated, and in 1986 we underestimated, the costs for the following fiscal years of our part B program, and were as a result forced to make corrections after the fact.

And to what might we attribute medicare part B's escalating unpredictability? We might start by considering the fact that the Medicare period beginning in 1984 and extending through this year saw the most radical changes in the program's implementation and reimbursement policies since Medicare's inception. The physician fee freeze, the PPS and MAAC systems, "overpriced" procedure reductions, DRG payment changes—once initiated, this constantly shifting combination of alterations immersed our health care program in the type of chaos which results from tremendous change over a very short period of time.

And so it has transpired that those responsible for continued future estimates of premium costs to the beneficiary have been presented with an immensely difficult task—forced, in fact, into almost blind prediction. I might even add here that the actuaries have done a commendable job over the past several years, all things considered.

At any rate, the point is that we are hardly in a position to speculate as to the reasons for a dramatic premium increase when we have subjected medicare to dramatic change for four years. The information at our disposal—the information on which we have been forced to make our out-year predictions—has been sketchy at best, and may result in misleading conclusions at worst.

Making ironclad predictions on which to base law in the midst of tremendous change is risky business and less-than-perfect governmental policy. I think that we are realizing that now.

And all of this deliberation and questioning over inadequate information and runaway costs calls to mind another, perhaps even greater concern: the catastrophic bill recently passed by the House and waiting in the wings to wreak havoc on an already-reeling and overburdened Medicare program.

If we are experiencing difficulties in correctly targeting out-year estimates for the cost of Medicare's current benefits, I hesitate even to imagine the potential complications which might arise from the introduction of substantial new benefits for which accurate cost projections will be extremely difficult.

The implementation of the majority's catastrophic health care plan can only exacerbate the problems we are addressing at this hearing. The future case, however, might find us attempting to determine ways of salvaging the entire Medicare program and re-instituting its solvency, rather than discussing only increases in part B premiums.

The bottom line is that we can guess, estimate, and predict all we want, but the fact that many are predicating their assessments of blame for Medicare's woes on less-than-adequate data will not go away.

It seems strange that we would insist each year on altering Medicare so drastically that we render it unmanageable, even unrecognizable from its original format—continuously expanding while expecting physicians to tighten their belts—and then wonder why we must raise part B premiums. I think that by this point it has become all too obvious.

Mr. Chairman, let's stop pointing fingers and start determining viable ways of controlling not only runaway premiums but a runaway governmentally-funded medicare system. I suggest that we stop asking doctors to tighten their belts and start tightening our own.

Instead of guessing and then realizing too late that we are wrong, let's exercise some restraint and take the time to create a responsible, manageable system that we know will be right—not only for beneficiaries or doctors, but for all citizens.

Mr. DONNELLY. Chairman Pepper, please proceed. Thank you so much for being with us.

STATEMENT OF HON. CLAUDE PEPPER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA, AND CHAIRMAN, SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, SELECT COMMITTEE ON AGING

Mr. **Pepper**. Thank you very much, Mr. Chairman, members of the committee. Mr. Chairman, I have a written statement which I offer for the record, if I may. And I would like to give sort of an oral summary of what I have proposed.

Mr. **Donnelly**. Without objection.

Mr. **Pepper**. Mr. Chairman, as you know, the administration proposes about a 38 percent increase in the amount that the elderly and the disabled will have to pay for the part B coverage under Medicare beginning January 1, 1988 unless Congress stops it or modifies that proposal.

I have introduced, along with the gentleman from Oregon, Mr. Wyden, a bill H.R. 3291, not to allow that increase to go into effect, but on the contrary to accelerate the present law which is going to go into effect January 1, 1989 which provides that the increase and the cost to be borne by the elderly for Medicare cannot exceed the cost of living increase. That is, the COLA.

Now that, as I said, is going to take effect, as I understand it, January 1, 1989. In view of the administration's declaration of need for an increased amount of revenue, I am proposing that we accelerate that law, let that provision take effect in lieu of the administration's proposal, January 1, 1988.

Now that would mean that there would be about a 4.2 percent increase in the amount of premium to be paid for part B of Medicare by the elderly and the disabled. Whereas, the proposal of the administration is the increase of 38 percent.

Now we know that since Medicare was inaugurated in 1965 that the cost to be borne by the elderly to participate in that program has steadily risen. One of the most glaring examples is the deductible for part A. It was around $40 or $50 when we enacted Medicare in 1965. Now it is $520.

And as a matter of fact, in 1966 the elderly were paying about $160 a year for their medical costs. Now they are paying about $1800 a year for their medical expense, an increase of approximately 1700 percent.

Now, Mr. Chairman and members of the committee, I think we should not add this additional burden upon the elderly and the disabled. To a large degree the fault for the administration's demand for a 38-percent increase in what the elderly shall pay is due to the administration's failure to hold costs down under part B of Medicare.

Now there is a DRG regulation which limits hospital costs, and we have made some progress in holding down under that regulation, hospital cost increases. But we have not applied the same principles to restrain increasing costs under part B of the Medicare program.

For example, we had an illustration of that at a hearing that my Subcommittee on Health and Long-Term Care had not long ago. We went into the matter of cataract operations upon the eye. We found out that if a patient in the hospital, so that the operation for cataract was covered by a DRG, there was about $2,000-odd restraint upon the amount of charge that could be made, the expense that might be incurred.

But if that same doctor operated upon that same patient in that same hospital but the patient was not an inpatient in the hospital, there was no regulation, and the doctor could charge anything he wanted to, or anyone else providing a contribution to that operation could charge anything he or she wanted to charge. I mentioned that to this committee at one time, and I hope maybe the committee will see fit to impose some regulations, some restraints upon those rising costs.

But in my opinion, therefore, if the administration had imposed some restraints upon increasing costs, as they have done on hospital costs that increased, we would not have this demand, I think, from the administration for a 38-percent increase.

Now my proposal, therefore, is that you not allow any increase more than by 4.2 percent, which is the anticipated COLA for 1988. That would cost about $12 billion over a period of 5 years. I propose that revenue shall be derived from and including—and I think the distinguished chairman of the subcommittee has already introduced a similar bill—including State and county employees under the Medicare requirement that they pay 1.4 percent of their income up to $45,000 for their Medicare expense.

If we were to include them, that would substantially take care of the cost that would be required to be increased for taking care of the elderly under part B of the program. Now that would not be a burden to anybody. It would not hurt the State and county employees, I think. And I am talking about not just those who come in after a certain time, but all State and county employees. I think they should be covered by Medicare, and that we ought to extend the coverage to them.

So what I am saying in substance, Mr. Chairman and members of the committee is, do not allow that 38-percent increase proposed by the administration to take effect. Simply accelerate the present law that makes a limit on the amount of increase in the cost that the elderly may have imposed upon them not to exceed the COLA, which would be anticipated for 1988, 4.2 percent. Limit the increase in the cost of 1988 to 4.2 percent. Raise the money to make up the difference extending to coverage to the State and county employees.

That is the gist of my proposal, Mr. Chairman. And I respectfully submit it to your distinguished committee.

[The statement of Mr. Pepper follows:]

[illegible]
Subcommittee on Health and Long-Term Care
House Annex 2. Room 377
Washington. D.C. 20515
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NEWS
Select Committee on Aging
U.S. House of Representatives

FOR IMMEDIATE RELEASE
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STATEMENT OF THE HONORABLE CLAUDE PEPPER, CHAIRMAN,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
OF THE
U.S. HOUSE SELECT COMMITTEE ON AGING
BEFORE
THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
ON

"THE ADMINISTRATION'S PROPOSED INCREASE IN ELDERLY'S SHARE OF MEDICARE PART B"

MR. CHAIRMAN. MEMBERS OF THE SUBCOMMITTEE. DISTINGUISHED GUESTS. IT IS A PLEASURE TO JOIN YOU TODAY AND SHARE WITH YOU MY VIEWS ON THE ADMINISTRATION'S PROPOSAL TO INCREASE THE ELDERLY'S SHARE OF THE MEDICARE PROGRAM. MR. CHAIRMAN, OUR NATION'S 31 MILLION OLDER AND DISABLED CITIZENS, WHO DEPEND ON MEDICARE FOR THEIR MEDICAL CARE ARE ONCE AGAIN UNDER ASSAULT FROM THE REAGAN ADMINISTRATION. IT IS EXPECTED THAT THE ADMINISTRATION WILL SOON PROPOSE A HUGE AND UNPRECEDENTED INCREASE IN WHAT OLDER AMERICANS ARE REQUIRED TO PAY FOR MEDICAL INSURANCE THROUGH PART B OF THE MEDICARE PROGRAM. UNDER THE ADMINISTRATION'S PROPOSAL, BEGINNING JANUARY 1, 1988, SENIORS AND THE DISABLED WOULD BE FORCED TO PAY NEARLY $300 A YEAR IN ORDER TO RECEIVE MEDICARE COVERAGE FOR DOCTOR AND OTHER MEDICAL SERVICES. THIS REPRESENTS AN INCREASE OF $82.80 OR 38.5 PERCENT FROM THE CURRENT YEARLY RATE OF $214.80 -- THE LARGEST INCREASE IN MEDICARE'S 23 YEAR HISTORY AND AT A RATE NEARLY TEN TIMES THAT OF INFLATION.

THE FACT OF THE MATTER IS THAT SENIOR CITIZENS ARE NOT RESPONSIBLE FOR THE NEEDED INCREASE, YET THEY WILL BE ASKED TO PAY FOR IT. THE PROPOSED INCREASE IS REQUIRED BECAUSE THIS ADMINISTRATION HAS FAILED TO ESTABLISH ADEQUATE CONTROLS OVER MEDICARE PART B SERVICES PROVIDED BY DOCTORS, HOSPITALS AND OTHERS OR TO CONTAIN COSTS OF SERVICES SHIFTED FROM THE HOSPITAL TO OUTPATIENT SETTINGS. THE DRG SYSTEM HAS PLACED FAIRLY RIGID CONTROLS ON WHAT MEDICARE WILL PAY FOR IN-PATIENT HOSPITAL SERVICES, BUT SIMILAR COST CONTROLS DO NOT EXIST FOR OTHER SERVICES. AS A RESULT, MANY PROCEDURES WHICH USED TO BE PERFORMED IN THE HOSPITAL HAVE SHIFTED TO OUTPATIENT SETTINGS, INCREASING PART B EXPENDITURES. TYPICAL OF SUCH A PROCEDURE IS CATARACT SURGERY. HEARINGS BY OUR SUBCOMMITTEE IN 1986 REVEALED THAT WE WERE PAYING MORE FOR SUCH SURGERY IN THE OUTPATIENT SETTING OF A HOSPITAL THAN WE WERE PAYING FOR IT IN THE HOSPITAL. IN ADDITION, THE CURRENT PART B PAYMENT SYSTEM ENCOURAGES DOCTORS AND OTHER PROVIDERS TO BOOST THEIR RATES AND TO PROVIDE MORE SERVICES. AS A RESULT, PHYSICIAN COSTS UNDER MEDICARE HAVE SKYROCKETED, RISING AT AN AVERAGE ANNUAL RATE OF 17 PERCENT.

ON SEPTEMBER 16, 1987, I INTRODUCED, ALONG WITH MY DISTINGUISHED COLLEAGUE FROM OREGON, MR. WYDEN, H.R. 3291, TO REVISE THE METHOD BY WHICH FUTURE INCREASES IN THE MEDICARE PART B PREMIUM ARE CALCULATED. UNDER, H.R. 3291, FUTURE ANNUAL INCREASES COULD NOT BE MORE THAN THE PERCENTAGE COST OF LIVING ADJUSTMENT (COLA) SENIORS' RECEIVE TO THEIR SOCIAL SECURITY BENEFITS. FOR 1988, PREMIUM INCREASES WOULD BE HELD TO 4.2 PERCENT, RATHER THAN THE PROJECTED 38.5 PERCENT. THUS, IF OUR BILL WERE ENACTED, SENIORS' MONTHLY PREMIUM WOULD RISE ONLY 80 CENTS A MONTH, FROM $17.90 TO 18.70.

OUR LEGISLATION IS NOT A MAJOR SHIFT IN THE MEDICARE LAW. PRIOR TO 1983, ALL PART B PREMIUM INCREASES WERE CAPPED AT A PERCENTAGE NOT TO EXCEED THE PERCENTAGE INCREASE IN THE SOCIAL SECURITY COST OF LIVING ADJUSTMENT. IN 1983, WE BROKE FROM THIS POLICY. BUT IN 1989, WE ARE SCHEDULED TO RETURN TO THE PRE-1983 POLICY. OUR BILL SIMPLY WOULD MAKE THIS EFFECTIVE RETURN DATE JANUARY 1, 1988. THE NATIONAL COUNCIL OF SENIOR CITIZENS, THE OLDER WOMEN'S LEAGUE, AND THE NATIONAL COMMITTEE TO PRESERVE SOCIAL

SECURITY HAVE ALREADY JOINED IN SUPPORT OF THIS MEASURE.

IT IS ESTIMATED THAT OUR BILL WOULD COST ABOUT $1.7 BILLION NEXT YEAR, AND ABOUT $12 BILLION OVER THE NEXT 5 YEARS. I WOULD SUGGEST TO THIS SUBCOMMITTEE THAT THE COST OF OUR BILL COULD BE PAID, IN LARGE PART, BY SIMPLY EXTENDING MEDICARE COVERAGE TO ALL STATE AND LOCAL EMPLOYEES. UNDER CURRENT LAW, MEDICARE HOSPITAL INSURANCE COVERAGE IS MANDATORY FOR EMPLOYEES OF STATE AND LOCAL GOVERNMENTS WHO WERE HIRED ON OR AFTER APRIL 1, 1986. IT IS OPTIONAL FOR THOSE HIRED BEFORE THAT DATE. BY ELIMINATING THIS OPTION FOR WORKERS HIRED BEFORE APRIL 1, 1986, IT IS ESTIMATED THAT ABOUT $10.4 BILLION OVER THE NEXT 5 YEARS COULD BE RAISED TO PAY FOR THE MAJORITY OF THE PART B FORMULA ADJUSTMENT ENVISIONED IN H.R. 3291. IF SUCH A CHANGE IS MADE, THE REVENUES GENERATED SHOULD CLEARLY BE USED TO BENEFIT THE MEDICARE PROGRAM, EITHER THROUGH LOWER COST SHARING BY SENIORS OR INCREASING OR IMPROVING BENEFITS.

CONTRIBUTING TO THE ELDERLY'S SKYROCKETING HEALTH CARE EXPENSES HAS BEEN THE RAPID ESCALATION OF MEDICARE PREMIUMS AND COINSURANCE SINCE THE PROGRAM'S INCEPTION IN 1965. IN 1966 THE AVERAGE AMERICAN AGE 65 AND OLDER SPENT SOME $110 ON HEALTH CARE. IN 1987, THE AVERAGE OLDER AMERICAN WAS FORCED TO PAY $1,800, AN INCREASE OF OVER 1700 PERCENT! PART B PREMIUMS HAVE NEARLY DOUBLED SINCE 1980 INCREASING FROM $108 to $214.80.

DESPITE THESE HUGE INCREASES IN THE COST OF HEALTH CARE TO OLDER AMERICANS AND THE RESULTING PHYSICAL AND FINANCIAL HARDSHIP, THE REAGAN ADMINISTRATION HAS REPEATEDLY PROPOSED EVEN FURTHER INCREASES. INSTEAD OF PROPOSING SENSIBLE WAYS OF CONTAINING HEALTH CARE COSTS FOR ALL, THIS ADMINISTRATION HAS CHOSEN TO SIMPLY PUT MORE OF THE BURDEN ON THE ALREADY OVERLADEN BACKS OF SENIOR CITIZENS.

MR. CHAIRMAN, I WOULD URGE THIS SUBCOMMITTEE TO DO OTHERWISE. I WOULD HOPE THAT YOU WOULD IMMEDIATELY SEEK REFORM AS PROPOSED IN H.R. 3291.

THANK YOU.

Mr. **Donnelly**. Thank you very much, Chairman Pepper. One of the problems with including State and local employees in Medicare, everybody on this committee except for me has a scheme on what program to spend that money on, and there are only so many employees from Massachusetts and Ohio to go around.

But be that as it may, Mr. Chairman, did you say that you would like to see physician services included under the DRG program similar to what we do with hospital services?

Mr. **Pepper**. Yes, I think they should be included. I think we should impose a DRG-type control upon the services rendered to the people covered by Medicare outside the hospitals.

Mr. **Donnelly**. I could not agree with you more.

Mr. **Pepper**. It should include physician's fees and other expenses related to the care provided to the elderly under Medicare outside the DRG coverage.

Mr. **Donnelly**. I could not agree with you more, Mr. Chairman, and I hope the committee would include that in reconciliation. That would go a long way to preventing these outrageous increases.

Are there any members of the committee that have a question for Chairman Pepper? Mr. Crane?

Mr. **Crane**. I do not have a question. I just want to commend the Senator for his testimony and his abiding concern and interest, and to report for members who may not be aware of it that Senator Pepper played in the Speaker's tournament on Monday and got a birdie. And if all folks in the Senator's age bracket were as able and capable as he is, we would not have any senior medical problems. Nice to have you with us, Senator.

Mr. **Pepper**. I thank the gentleman very much.

Mr. **Donnelly**. Mr. Pease.

Mr. **Pease**. Thank you, Mr. Chairman. Senator Pepper, it is always a delight to have you before the committee. My understanding is that the law to which you refer, it will limit Medicare premium increases to the amount of the COLA increase, was originally passed in 1972. Is that your understanding? And that at the time it was passed in 1972, premiums from beneficiaries were making up about 50 percent of the cost of providing part B services.

Mr. **Pepper**. I guess it is a matter of policy determination to determine what part of the total cost the elderly should pay and what part should be paid by general revenue. But I do not think we should increase, I will say to my friend, more than a minimum amount. This 4.2 formula would bring about an increase about $1 a month, from $17.90, I believe, to $18.70 or something like that. That would not be burdensome.

But to go on and increase the amount they would now have to pay if this administration proposal were put into effect, from $214 a year to almost $300, about an $80, $82 increase. That is a considerable amount, when you take into account that the average Social Security check is approximately $400, a little over $400. That means that about half of the people make less than $400 a month on their Social Security. So an increase—$5 to some of those people is a lot of money.

So I think we ought to adopt this formula that the Congress has already established, limiting the increase to the COLA. Now that will not be too burdensome.

Mr. **Pease**. Thank you, Senator.

Mr. **Pepper**. And whatever balance remains will have to be derived from some other source, either state and county employee coverage or increase in the amount of the public contribution.

Mr. **Pease**. My understanding is that under the 1972 act the percentage of total part B costs covered by the premium gradually went down from 50 percent to about 25 percent, and in 1982 Congress passed the law which is now in effect which said that the figure would stay at 25 percent. And it is that 1982 provision which would expire on January 1 of 1988. Is that your understanding also?

Mr. **Pepper**. My friend, I will say it is a question of which way you look at it. I look at it from the viewpoint that the elderly were paying about $160 in 1966. Now they are paying about $1800. This would raise their payment for the year from $214 to $300. Now we know that our bill that we passed a little bit ago will add several hundred dollars a year to the amount the elderly will have to pay, so that is to be taken into account also.

So I just think that we have to be very careful about how much we add to the burden of the elderly to pay.

Mr. **Pease**. I understand that, and I also sympathize with it. If you say that we are holding the premium costs to beneficiaries at 25 percent and no change, that sounds like it is not very much or anything. But the question is, 25 percent of what, and you make that point, I think, very well.

The other question I would like to ask you, Senator, is this. In providing for the funding of the catastrophic health care provisions, this committee rejected the administration's proposal for a flat, across-the-board fee to everybody on Medicare to pay for that. Instead we deliberately had a very small increase flat across the board and paid for most of the increase or most of the cost of catastrophic health with an income related premium, a special premium which does not at all hit people earning under $6,000 a year, but would draw on other people who earn over that amount.

I guess my question is whether you would think it might be appropriate for us to apply the same principle to this current problem.

Mr. **Pepper**. Mr. Pease, there is some rationality behind that proposal, although—and I commend this distinguished committee for not going along with the administration's request in that matter, which would have been an obvious error. On the other hand, I rather reluctantly see us begin to divide the elderly, those who have larger incomes and those who have smaller, while there is a rationale behind it.

But it is like, personally, I do not favor anybody paying income tax on Social Security benefits. I hope sometime we will repeal what we did in 1983. I would like the elderly to be regarded as a group, and in our policies we take into account those at the bottom of the group as well as those at the top, but without having to make a distinction so that one rate applies to one group and another rate to another group.

But there is sense in that, and at least it is better than the administration's proposal in that respect.

Mr. **Pease**. Thank you very much.

Mr. **Donnelly**. Mr. Daub.

Mr. **Daub**. First, let me say to my good friend how much I enjoyed my 4 years on the Health and Long-Term Care Subcommittee. We enjoyed an opportunity to get acquainted, and I know of the Senator's deep concern for the elderly.

And I am really impressed by his answers to Mr. Pease's questions and just want to emphasize, really without asking a question, that your concern was evidenced by the work that Mr. Donnelly and I tried to do with respect to long-term care and nursing home care. And I know that you have approached this problem as well. That is where the true catastrophic costs are.

But if in the process we are today concerned about an increase in the premium of 38.5 percent—and we are—and we are concerned about the elastic or inelastic effect of that increase on an elderly person that is on fixed income, because part B is voluntary and we keep raising the premiums, some of those folks are going to decide not to take that coverage. They are going to fall off the program, if you will.

And so when we take a look at it today, with current services costing 38.5 percent more than last year, think of the problem when we add catastrophic legislation of any kind to a premium that might make that voluntary cost something like $50 a month or $70 a month, which is what some of the projections indicate. And I think we have to be a lot more cautious in expanding our programs relative to those middle or near poor people who are elderly who maybe will just choose not tc take the coverage. That will create, I think, some very serious social problems among the elderly as well.

Mr. **Pepper**. I thank the gentleman for his proposal. He knows I commend him very highly for the contribution he made to our subcommittee.

Mr. Chairman, in conclusion I would ask, if I may, your consideration, your committee to give serious consideration to applying DRG principles to expenditures outside the hospital. That is where the increase has gone up. And I think if we applied some restraints there, it would not be necessary, maybe, to have some of these costs that we are anticipating.

Mr. **Donnelly**. Senator, I could not agree with you more on that issue, and your support will be of immeasurable value.

Mr. **Pepper**. Thank you.

Mr. **Donnelly**. Thank you very, Senator. The committee stands——

Mr. **Daub**. Mr. Chairman, before you adjourn may I——

Mr. **Donnelly**. Mr. Daub.

Mr. **Daub**. I understand that Mr. Gradison, my ranking member, offered the testimony that I would give orally to the record and that you have agreed to make that testimony a matter of record; is that correct?

Mr. **Donnelly**. For the gentleman's edification, it is already in the record.

Mr. **Daub**. I appreciate that. I would like my colleagues to just take note of that testimony for I discuss in it things that Mr. Stark brought up in his own questions with Dr. Roper, particularly with respect to the intensity of delivery, the technology costs, and population demographics. And those are very important ideas. I agree that we do not know enough yet about them, but I think we had better understand them better before we try to tamper with Part B.

Mr. DONNELLY. It will be a mandate of the chair that all members read the gentleman from Nebraska's remarks.

Mr. DAUB. Thank you, Mr. Chairman.

Mr. DONNELLY. The Chair will stay in recess until 1:15.

[Whereupon, at 12:07 p.m., the committee meeting was recessed, to reconvene at 1:15 p.m.]

AFTERNOON SESSION

Mr. STARK. The committee will proceed with its hearing and welcome the Honorable Lawrence J. Smith from the great State of Florida.

STATEMENT OF HON. LAWRENCE J. SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. SMITH. Thank you, Mr. Chairman. Mr. Chairman, thank you for the opportunity to testify before the Ways and Means Committee to express my opposition to the proposed increase in Medicare part B premium. I commend you and the committee for your efforts to focus congressional attention on the reasons precipitating the Department of Health and Human Services action, and their action to announce such a drastic, and in my opinion, unwarranted increase.

None of us here today dispute the fact that medical care costs are rising at alarming rates. Between 1976 and 1988 outlays for supplementary medical insurance—part B—increased over fivefold compared to the part A hospital insurance outlays which have tripled. Program outlays have increased, not only because of inflation and growth in enrollees, but also due to increasing prices and intensity of services. For example, payments for physician services have increased by 345 percent between 1975 and 1985.

Despite this, we are still faced with the same question with no clear solutions in sight. What can be done to control costs? As elected officials we share a commitment to provide quality health care for our Nation's elderly and continue to bring costs under control.

Secretary Bowen's recent action will force Medicare beneficiaries to pay a 38.5 percent increase in premiums rising from just under $18 to almost $25 per month for part B care. This increase places unnecessary burdens on the senior citizens and the beneficiaries of Medicare.

Already I have received numerous letters and calls from constituents complaining about the effects of this proposed increase. Let me just add that in my district about 28 percent of the constituents are on Social Security. It is the biggest single economic factor in Broward County in Florida. One constituent wrote to me saying, "I cannot afford to eat as it is, any more pressures for money and I will commit suicide." Another letter said, "Such a large increase is unconscionable. If permitted to stand, it would further erode the standard of living of countless senior citizens who are already struggling to make ends meet in the face of the ever-rising inflationary spiral."

Increasing the premium year after year is only a temporary solution to the problem. More stringent monitoring of quality of care and costs of the Medicare program should and must be implemented by the Health Care Financing Administration. HCFA must check for abuse and overuse of the system by both patients and doctors and not shift blame from doctors to providers and back to doctors and patients while failing to reach any workable solution to this problem.

We need alternatives. Plain and simple, the Medicare system is overburdened. Elderly people often fear illness, and patients who may not actually be sick use the doctors as a crutch. Often I hear, "I will go to a doctor just to make sure that there is nothing wrong with me." This only increases the burden on the Medicare system.

In addition, we also have the usual problems associated with the elderly and advancing old age. And I might add, in my district I have one of the most significant graying elderly populations, people who have been retired 20, 25, and even 30 years who never expected to live so long. They have no spouse. Families do not come to see them any longer. They are separated from any real family they have. They are alone. They are frightened. And psychologically, they have no alternatives.

So what do they do, they take a whole day to see the doctor. They do not really have an illness, but they convince themselves they do. And it is something that we have to be concerned about, because I believe that HCFA is not prepared for those people using the system.

And HCFA must find those alternatives that will not drain the Federal resources. Doctors very rarely call patients to come in and ask them to see them. But we all know that many patients go to the doctors without hesitation because they have Medicare. In addition, many may feel that since they are paying—if this goes through especially—much higher premiums, they are absolutely entitled to use the Medicare system any time regardless of actual need.

And in a way, these increases are counterproductive, because the propriety of using Medicare becomes a more important factor. The more people pay, the more they think they are entitled to use the system as much as they want. And in a way, you cannot blame them.

While we must work toward a long term solution to the problem of rising health costs, I am pleased to take action to temporarily curtail the increase. I have joined with my colleagues as a cosponsor of H.R. 3291, which would limit future increases in part B to no more than the percentage COLA that seniors receive to their Social Security benefits. I certainly encourage others to join me in supporting this type of legislation, only as a temporary measure until the real solutions can be found.

In addition to the financial burdens placed on Medicare beneficiaries by the proposed increase, I would like also to draw the committee's attention, Mr. Chairman, to another recent announcement by the Department of Health and Human Services.

Frankly, I was outraged to learn that the administration has proposed to curtail face-to-face hearings for individuals who contend they have been improperly denied benefits under Medicare. According to this new proposal, hearings would be conducted on the telephone by an administrative law judge employed by the Medicare agency. This would no longer provide an opportunity for appeals to be heard by unbiased, neutral administrative law judges.

Instead, the ALJ's as employees of the agency, would lose their objectivity. In addition, a drive by the agency, as we have seen in the past to cut costs, to cut appeals like they did with Social Security and disability beneficiaries would significantly reduce the number of people who could appeal their cases or have access to an unbiased appeals program. I am hopeful that this committee will also address this action which is detrimental to the Medicare program.

This administration's proposals, both for increased premiums and decreased rights, show a lack of consideration for the beneficiaries—those for whom the program was designed in the first place. Changing to strictly a telephone procedure threatens the independence and integrity of the Medicare and appeals programs. After all, how many people want to appeal their Medicare claims over the phone?

Have you ever tried to make a call to the Medicare system? Have you ever tried to get an appropriate response after waiting on the phone, as even my administrative assistants do at home, after 20 or 30 minutes of being shuffled around and put on hold? What about an individual's right to have an attorney at a hearing? Are you going to have an attorney on a conference call? This is difficult to do certainly, over the phone. What about hearing impaired elderly and seniors—and there are an awful lot of them.

Implementing this proposal would only cause more appeals, more paperwork and more strain on an already abused system.

Raising premiums to combat costs also only hurts beneficiaries. We have done it over the years and it has not stopped the escalation. When will this administration begin to worry about the people we serve and not the system? When will they care more about those that need help and less about the job of those whose job it is to serve? When will they be creative to find answers that "do not stick it to the elderly?"

We have a commitment, Mr. Chairman, to provide quality, decent health care for older Americans. I know that all the members of this committee share that commitment. We also have a commitment to maintain a Medicare program that is fiscally responsible and provides cost efficient health care for all those in need. I remain committed to working with you and all our colleagues to achieve that goal.

That concludes my statement, but if I might, Mr. Chairman, just take 30 seconds as an aside. I understand that Dr. Roper in his testimony talked about supporting capitation for physicians, and talked about establishing demonstration projects to study this.

Let me just say that with reference to those items, if you want a good, quick and accurate reading of how that might work, just look at the HMO demonstration projects that started in 1982 in Florida. It is the best argument against this approach that I could ever muster. That system was atrocious, leading to the debacle in 1986 and 1987 of IMC and other demonstration projects.

They never paid any attention to them. They never collected any statistics. They never sent inspectors out to check the quality of health care, et cetera. And the chairman and the committee members certainly know what I am talking about. And I would urge this committee not to take that approach at all. In fact, not only would it not help, I think it would drive the system further into ruin.

Thank you, Mr. Chairman.

[The statement of Mr. Smith follows:]

STATEMENT OF THE HONORABLE LAWRENCE J. SMITH
BEFORE THE HOUSE WAYS AND MEANS COMMITTEE
SEPTEMBER 30, 1987

Mr. Chairman, thank you for the opportunity to testify before the Ways and Means Committee to express my opposition to the proposed increase in the Medicare Part B premium. I commend you for your efforts to focus Congressional attention on the reasons precipitating the Department of Health and Human Services to announce such a drastic, and in my opinion unwarranted, increase.

None of us here today disputes the fact that medical care costs are rising at alarming rates. Between 1976 and 1988 outlays for supplementary medical insurance (Part B) increased over **five-fold** compared to the Part A hospital insurance outlays which have tripled during this period. Programs outlays have increased, not only because of inflation and growth in enrollees but also due to increasing prices and intensity of services. For example payments for physician services have increased by 345% between 1975 and 1985.

Despite this, we are still faced with the same question with no clear solutions in sight. What can be done to control costs? As elected officials we share a commitment to provide quality health care for our nation's elderly and continue to bring costs under control.

Secretary Bowen's recent action will force Medicare beneficiaries to pay a 38.5% increase in premiums rising from $17.90 to $24.90 per month for Part B. This increase places unnecessary burdens on the senior citizen beneficiaries. Already I have received letters and calls from constituents complaining about the effects of this proposed increase. One constituent wrote to me saying "I can't afford to eat as it is, any more pressures for money and I will commit suicide." Another letter I received said, "Such a large increase is unconscionable...if permitted to stand, it would further erode the standard of living of countless senior citizens who are already struggling to make ends meet, in the face of the ever-rising inflationary spiral."

Increasing the premium year after year is only a temporary solution to the problem. More stringent monitoring of quality of care and costs of the Medicare program should be implemented by HCFA. HCFA must check for abuse and overuse of the system by both patients and doctors and not shift blame from doctors to providers and vice-versa while failing to reach any workable solution to this problem.

We need alternatives. Plain and simple the Medicare system is overburdened. Elderly people often fear illness, and patients who may not actually be sick use the doctors as a crutch. Often I hear, "I'll go to a doctor just to make sure that there is nothing wrong with me." This only increases the burden on the Medicare system. HCFA must find alternatives that will not drain our federal resources. Doctors very rarely call patients and ask them to come see them, but we all know that many patients go to the doctors without hesitation because they have Medicare. In addition, many may feel that since they are paying higher premiums, they are entitled to use the Medicare system any time regardless of actual need.

While we must work toward a long-term solution to the problem of rising health costs, I am pleased to take action to temporarily curtail the increase. I have joined with my colleagues as a cosponsor of H.R. 3291 which would limit future increases in Part B to no more than the percentage COLA seniors receive to their Social Security benefits. I encourage others to join me in supporting such legislation.

In addition to the financial burdens placed on Medicare beneficiaries by the proposed increase, I would also like to draw the Committee's attention to another recent announcement by the Department of Health and Human Services. I was outraged to learn that the Administration has proposed to curtail face-to-face hearings for individuals who contend they have been improperly denied benefits under Medicare. According to the proposed plan, hearings would be conducted on the telephone by an administrative law judge employed by the Medicare agency. This no longer provides an opportunity for appeals to be heard by unbiased, neutral administrative law judges. Instead, the ALJ's as employees of the agency, would lose their objectivity. I am hopeful that the committee will address this action which is detrimental to the Medicare program.

This Administration's proposals shows a lack of consideration for the beneficiaries--those for whom the program was designed in the first place. Changing to strictly a telephone procedure threatens the independence and integrity of the Medicare program. After all, how many people want to appeal their Medicare claims over the phone? What about an individuals right to have an attorney at a hearing? This is difficult to do over the phone. What about the hearing-impaired? Implementing this proposal would only cause more appeals, more paperwork, and more strain on an already abused system.

Raising premiums to combat costs only hurts beneficiaries. We've done it over the years and it hasn't stopped the escalation. When will this Administration begin to worry about the people we serve, not the system? When will they care more about those that need help and less about whose job it is to serve? When will they be creative to find answers that don't "stick it to the elderly?"

We have a commitment to provide quality, decent health care for older Americans. We also have a commitment to maintain a Medicare program that is fiscally responsible and provides cost-efficient health care for all those in need. I remain committed to working with my colleagues to achieve this goal.

Mr. **Stark**. Thank you, Larry. I share your frustration, occasionally with HCFA who, while they return phone calls from members quickly, do not quickly complete reports that we were to receive and are sometimes 2 and 3 years coming.

We have been told, in regard to this issue of phone appeals, that for the first 20 years or so of Medicare there were not any appeals allowed. If what I am about to relay to you is correct, it may ease some of both of our fears away. I hope you will monitor this.

I am told that 90 percent of the calls or the appeals that are anticipated will be from physicians who are questioning the disallowance of their billing. I am perfectly willing to submit that if this saves the physician time, and if the physician is talking to somebody who understands the words and the technical details, they can probably get it done over the phone. I am skeptical, but I hope that you will relay to us anything that you have that shows anything different.

Mr. **Smith**. If I might, Mr. Chairman, on that issue directly I can already tell you that there is an ongoing appeals process that doctors do have as an adjunct of the Medicare system. My office spends countless hours a month helping doctors take appeals because Medicare will not talk to them. The third party——

Mr. **Stark**. As I understand, now they are going to talk to them.

Mr. **Smith**. The third party provider in Florida, Blue Cross/Blue Shield, frankly had a terribly inadequate system for doing that. Records were lost, they could not get anybody that knew the case on the phone, et cetera.

Mr. **Stark**. I am willing to see what happens. But I wanted to submit to you that this is not involving our beneficiaries. If that were the case, I would share your concerns that they have to be allowed to have a face-to-face hearing.

Mr. **Smith**. I would be happy to follow that along, absolutely.

Mr. **Stark**. The other thing that I am also informed by my staff of, is that in terms of visits, they have maintained relatively constant. We have not had much of an increase.

Now if your constituents are visiting their urologist or their proctologist or their cardiac surgeon as a way to spend an afternoon, I wish them godspeed. But I do not think that is the case. I think that it may be kind of fun for the beneficiaries to talk with their doctor and complain about their aches and pains, and this has not cost us much money, mostly because these office visits are not the highest priced procedures being billed. I hope we do not have to cut back on these office visits.

My own opinion is that the primary care or the cognitive physicians are the ones that the seniors ought to be visiting. It is the physicians providing the high priced procedures that they ought to try to avoid.

I share with you, and I know this committee does, the concern for the beneficiaries, they are the ones who pay the bills, as do the rest of the taxpayers. I appreciate you sharing your insights with us. You have been very helpful in the past to this committee and I encourage you to stay active in this field, it helps us and I know it is of benefit to your constituents.

Mr. **Daub**. Mr. Chairman?

Mr. **Stark**. Mr. Daub.

Mr. **Daub**. Thank you very much, Mr. Chairman. And Mr. Smith, thank you very much for sharing your views and some of the experiences that you and your Florida constituents have had. And I know of the great difficulty—the IMC difficulty that you and your constituents and many others had in Florida.

There are some capitation plans though, Kaiser Permanente's, California, Minnesota, where we have had better experiences. So we are learning. I think in Florida we started off with a pilot project, that did not have the 50/50 rule. We have learned a lot I think, about some of the mistakes of the past. So I am not so sure that they ought to be more than learning experiences and to take a look at better managing the opportunity for capitation. We might have learned enough lessons that we can do a better job now for folks than we did before. But I do think your caution is welcome. The committee has that same view.

And with respect to the part B appeals process, we have mandated that process, Mr. Chairman, if I understand correctly. We did not tell HCFA how to do it, but the Congress told them to do it. To the extent that phone appeals could handle 60 or 70 or 80 percent of appeals—people have to travel out in my part of the country long, long miles to go face-to-face anyway—it may be possible to get a lot of this done.

And I understand under the regulations that are proposed that those that are of handicapped circumstance or have special circumstance will have a face-to-face hearing with the ALJ. This telephone hearing process does not consist any of a random phone call where ALJs will pick up the phone and call in, and sorry, if you are not there, there is no appeal. These are set up in advance.

So we will watch these telephone hearings carefully, but we hope we can handle most of it this way. And there may be a need to beef up the care and the consideration and the personal attention in these hearings. And as the chairman said, we would welcome your input as this preliminary appeals process starts. And if there are kinks in it, if does not work right, please let us know just as quickly as possible so that we can ask the administration to modify their procedures as they attempt to handle these appeals.

Thank you.

Mr. **Smith**. Thank you, Mr. Chairman. All I can say is, if there is something that is going to go wrong with it, in my district you are going to hear about it first. And I will have hundreds of calls the very next day after the implementation. And you can be sure I will be more than happy to forward all of those kinks to this committee.

Mr. **Stark**. Thanks a lot.

Mr. **Smith**. I want to just compliment this committee and the chairman. You have all been very, very helpful in areas—not only mine, but a lot of other places. As you know, Florida certainly has a large population of elderly. And the people of my State and my area are very grateful for the continuing overview that you keep of the medical and health care system because to them, as you know, it is their very life that is at stake.

Mr. **Stark**. Thank you very much, we appreciate it.

Mr. **Smith**. Thank you, Mr. Chairman.

Mr. **Stark**. Our next witness is Ms. Nancy Gordon, the Assistant Director of Human Resources with the Congressional Budget Office, accompanied by persons that she will introduce to the reporter and the Chair.

Ms. **Gordon**. I would be happy to.

Mr. **Stark**. We have your prepared testimony, Ms. Gordon, and you may expand on it, summarize it, and/or paraphrase it to us in any way you are comfortable.

STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE, ACCOMPANIED BY SANDRA CHRISTENSEN AND HOLLY HARVEY, ANALYSTS, CONGRESSIONAL BUDGET OFFICE

Ms. **Gordon**. Thank you very much, Mr. Chairman, I appreciate that. Dr. Gramlich asked me to express his regrets that his schedule does not permit him to participate in the hearing this afternoon. I would like to introduce Sandra Christensen, who is seated to my right, and Holly Harvey, who is seated to my left, who are the analysts responsible for working on the SMI program at the Congressional Budget Office.

Mr. **Stark**. Welcome to the committee. Thank you.

Ms. **Gordon**. Because the first two sections of my statement discuss material that was covered in detail this morning, I would like to just mention the bottom line from them. First, the $24.80 premium promulgated by HCFA appears to be reasonable. It is in the middle of the range of values that is presented in table 1 on page 6 of the prepared statement.

Second, if there is a problem in setting premiums it is that, in retrospect, the premium was set too low in the preceding two or three years.

I would like to spend the remainder of the time talking about the impact of the announced premium increase on enrollees and possible congressional responses. This section begins on page 13 of the prepared statement.

With the announced premium increase, enrollees will pay $298 in 1988 for SMI premiums, or $83 more than the $215 they pay this year. The annual premium will represent 2.9 percent of median per capita income for Medicare enrollees, which is estimated to be about $10,400. Although the premium increase is small relative to income for most Medicare enrollees, it could represent a significant amount for enrollees with low incomes who are not protected by other government programs.

About 9 percent of enrollees, or 2.9 million people, will be protected because they are also eligible for Medicaid, which typically pays their SMI premiums along with most other out-of-pocket expenses. Another 1.6 percent of enrollees, or another half a million people, will be partially protected by the so-called hold-harmless provisions of Public Law 98-369, which stipulates that the dollar increase in the SMI premium for an enrollee cannot exceed the increase in Social Security benefits that the beneficiary would receive as a result of the annual cost-of-living adjustment.

But approximately 9 percent of enrollees—2.9 million people—with per capita incomes less than $5,000 in 1988, and an additional 15 percent of enrollees—4.8 million people—with per capita incomes less than $7,500, would not be protected by either of these provisions.

If the Congress wishes to reduce the impact of the premium increase on enrollees in 1988 it has two options. It could shift costs to non-Medicare groups, or it could shift costs to Medicare enrollees in later years. In either case, the Federal budget deficit for 1988 would be increased unless taxes were raised by enough to offset the costs. Furthermore, special appropriations to the SMI trust fund, in addition to the appropriations provided under current law, might be required to ensure timely payment of claims.

Finally, because the new SMI premium and the Social Security cost-of-living adjustment both go into effect in January 1988, consultations with officials of the Social Security Administration to determine the administrative feasibility of any particular option would have to begin immediately.

One possible response proposed by Congressman Pepper was discussed earlier today. It would limit the percentage increase in the premium to the estimated cost-of-living adjustment to be provided for 1988 Social Security benefits. In this case, the premium would rise by only 4.3 percent, to $18.70. This option would protect all Social Security recipients regardless of their incomes, but it would raise the Federal deficit by an estimated $1.7 billion in fiscal year 1988, and by $12 billion over the next 5 years relative to current law.

A less costly alternative would be to limit the premium increase only for enrollees with low benefits. The current hold-harmless provision could be modified to assure that each beneficiary would receive a Social Security check, net of the deduction for the SMI premium, that was higher by at least $7 a month or by the full amount of the COLA, whichever was lower.

In 1988, this option would increase the number of enrollees who would receive some subsidy of their SMI premium from about half a million to nearly 7 million. This option would raise the Federal deficit by about $200 million in 1988 and by nearly $1.5 billion over the next 5 years.

A disadvantage stems, however, from the fact that some recipients of low Social Security benefits have sizeable incomes from other sources. Thus, about 47 percent of those who would gain from this option will have per capita incomes over $10,000 in 1988.

Turning now to options for the long term, a major concern about the premium increase just announced is the size of the 1-year jump, more than 38 percent. Yet because premium increases had been held down for the previous three years, the average rate of growth in the SMI premium from 1984 through 1988 is a more moderate 14 percent, closely tracking the expected average growth in costs per aged enrollee over the same period.

Under current law, large 1-year increases in the SMI premium are unlikely to occur in the future because growth in the premium will be limited by the COLA beginning in 1989. But if the Congress continues each year to extend the period during which the SMI premium is set at 25 percent of costs per aged enrollee, as it has done since 1984, future increases would probably be volatile.

Under the latter circumstance, volatility in the size of future SMI premium increases could be reduced over the long term by instructing the trustees to build up a larger reserve than has been their goal in recent years. This action would necessitate higher premiums on average than would otherwise be required over the next several years, while a surplus was being built up. Once in place though, the trustees could use the flexibility provided by the larger reserve to dampen premium increases in periods of unusually rapidly rising costs, and then replace the reserve through higher premiums in periods of slower growth in costs.

In principle, the trustees have this flexibility now, but it was partly concern about negative public reaction to their maintaining a large reserve that led to its rapid reduction from 1985 through 1987. Explicit instructions by the Congress to maintain a positive but flexible reserve could prevent such a situation in the future. For example, the Congress could provide specific guidelines regarding minimum and maximum desirable values for the trust fund's reserve.

The more fundamental solution for rapidly rising premiums, however, is to contain costs. Efforts to do so have focused only on price restraint to date, but containing costs requires placing limits on the volume of services as well. Control of both price and volume might be achieved in alternative ways, including establishing stringent utilization review programs under the current fee-for-service payment system, or introducing a capitated payment system. The issues involved are complex, however, and beyond the scope of this statement. My understanding is that testimony of the Physician Payment Review Commission will focus on this topic.

Thank you, Mr. Chairman. I would be pleased to answer any questions.

[The statement of Ms. Gordon follows:]

Statement of
Nancy M. Gordon
Assistant Director for
Human Resources and Community Development
Congressional Budget Office
before the
Committee on Ways and Means
U.S. House of Representatives
September 30, 1987

The Administration has just announced that the 1988 premium for Medicare's Supplementary Medical Insurance (SMI) program will be $24.80 a month, an increase of $6.90 a month over its 1987 value. A relatively large increase had already been anticipated for 1988. This expected raise in premiums was to have resulted partly from increases in payment rates following termination of the SMI physicians' fee freeze, and partly from the artificially low premiums set in 1987 to complete the trustees' deliberate reduction of large reserves in the SMI trust fund. The 38.5 percent increase just announced, however, is considerably larger than the projections both the Health Care Financing Administration (HCFA) and the Congressional Budget Office (CBO) made earlier this year.

My testimony today will cover:

- The factors that influence the level of the SMI premium, and difficulties in forecasting them;
- The underlying causes of rapid growth in SMI costs; and
- The impact of the announced increase on enrollees, as well as possible Congressional responses.

FACTORS THAT INFLUENCE THE LEVEL OF THE SMI PREMIUM 1/

Current law requires that the 1988 SMI premium be set at 25 percent of the average monthly benefit per aged enrollee. Beginning in 1989, however, the SMI premium cannot rise faster in percentage terms than the most recent cost-of-living adjustment (COLA) provided for Social Security beneficiaries. 2/ Because the COLA is projected to be noticeably lower than the increase in average SMI costs, this limitation means that after 1988 the increase in the premium will be determined by the COLA.

Because the SMI premium is set in advance each year, the 1988 value must be based on an estimate of the average benefit in the coming year. Further, this estimate must be based on incomplete information about what has occurred in preceding years. 3/ Consequently, considerable uncertainty surrounds any estimate. As will become clear, an appropriate premium, based on the latest information available, could range from nearly $23 to nearly $27 a month.

The SMI Trust Fund

To understand the specific issues involved in choosing a value for the 1988 premium, some background on the operations of the SMI trust fund in recent years is useful. It is especially important to understand how the trust fund's reserve—defined as assets less unpaid expenses—has influenced decisions about the premium.

By law, the operations of the SMI trust fund are on an incurred basis—that is, premiums are set so that receipts (enrollees' premiums plus related government contributions) each year will equal the expected costs of services provided during that year. As a result, the trust fund's assets at the end of each year would be just enough to cover anticipated unpaid expenses.

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1. This section refers to calendar years.
2. The average monthly benefit includes related administrative costs and is adjusted for interest receipts and a contingency allowance that compensates for past projection errors. It is twice the monthly actuarial rate promulgated by HCFA.
3. Currently, near the end of 1987, only information for calendar year 1984 is considered final. Claims for 1986 and, to a lesser extent, for 1985 are still incomplete. Therefore, only estimates of spending are available for those years.

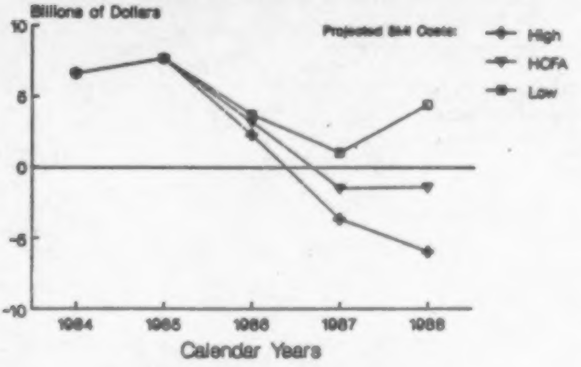
Because projections are subject to error, the trust fund's reserve at the end of the year is not necessarily zero. It is either positive or negative, depending on whether actual costs were lower or higher than projected. In subsequent years, then, the trustees generally incorporate a contingency margin to amortize the cumulative result of previous errors in projection.

The trust fund can accommodate a negative reserve to some extent because of the "float." In particular, revenues flow evenly into the trust fund during the year, roughly matching the rate at which costs for benefits are incurred, but payments for those benefits occur with a lag. Consequently, even when the reserve is about zero, the fund has a positive cash balance of 10 percent to 15 percent of annual payments. A succession of years in which receipts were less than costs would eventually exhaust this trust fund.

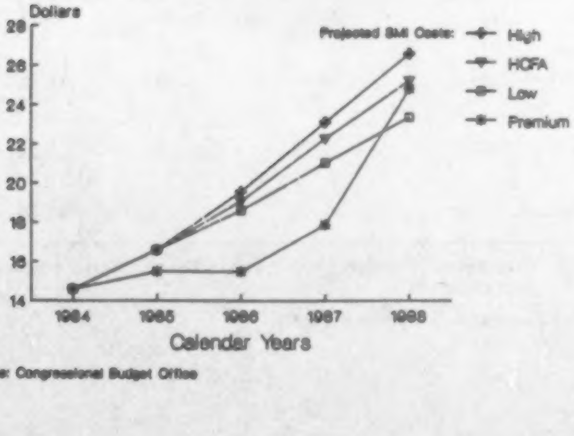
Figure 1 illustrates these concepts by showing the actual experience of the SMI program for 1984 and 1985, as well as alternative projections for

Figure 1.

SMI Trust Fund's Reserve, 1984-1988
(Excess of Assets Over Unpaid Expenses)



SMI Costs Per Enrollee and
SMI Premiums, 1984-1988
(Costs Scaled to Match 1984 Premium)



Source: Congressional Budget Office

988 through 1988. Because costs were less than projected for some years in the early 1980s, the trust fund's reserve at the end of calendar year 1984 was large. As the top panel of the figure shows, the reserve equaled $6.6 billion, which represented more than 25 percent of expected liabilities for 1985. The bottom panel indicates that, to reduce this surplus, premiums for 1985 through 1987 were raised less rapidly than the growth in costs per aged enrollee.

The 1987 premium was set so that, if actual costs matched the projected ones, the reserve at the end of 1987 would be near zero. It appears, however, that costs for 1987 will be from 6 percent to 16 percent higher than was expected when the 1987 premium was set. As a result, the trust fund's reserve will probably be negative at the end of 1987. In other words, the fund's cash balance, although positive, will be less than unpaid expenses.

Uncertainties in Setting the Premium

Table 1 illustrates some of the uncertainties that enter into setting the premium for 1988. The assumptions underlying the first column would generate a relatively low premium; the second column shows HCFA's estimates; and the third column represents a relatively high premium.

TABLE 1. SMI PREMIUM UNDER ALTERNATIVE ASSUMPTIONS, 1988 (In dollars)

	Low	HCFA a/	High
25 Percent of Estimated Incurred Expenditures for 1986	18.30	18.77	19.24
times			
Multiplicative Growth Factor for 1987	1.13	1.17	1.18
equals			
25 Percent of Estimated Incurred Expenditures for 1987	20.67	21.88	22.70
times			
Multiplicative Growth Factor for 1988	1.11	1.13	1.15
equals			
25 Percent of Estimated Incurred Expenditures for 1988	22.95	24.77	26.11
plus			
Value of Interest	-0.05	-0.03	-0.02
plus			
Contingency Margin	0.00	0.07	0.80
equals			
1988 Premium	22.90	24.80	26.89

SOURCE: Congressional Budget Office and Health Care Financing Administration.

a. As announced on September 30, 1987.

An estimate of future costs is typically based on the latest available information about past costs, but even the value of incurred costs for 1986 is not yet known. 4/ Because enrollees may delay submitting claims for up to 12 months after the end of a given benefit year, a firm assessment of incurred costs for 1986 will not be possible until early in 1988. The only data available promptly are on outlays from the trust fund, which may differ significantly from incurred costs. Thus, the top row of Table 1 gives a range of alternative values for the "premium base" for 1986--that is, for one-fourth of the costs that were incurred in 1986.

Another uncertain factor is the rate of growth in costs since 1986. Estimates of growth during 1987 are influenced by the change in outlays observed in 1987 relative to a comparable period in 1986, but this change may or may not accurately reflect growth in incurred costs. The second row of Table 1 indicates that the 1987 growth rate could be as low as 13 percent; about 17 percent, as assumed by HCFA; or as high as 18 percent. 5/ The third row of the table shows the 1987 base for projecting the 1988 premium that results from these assumptions.

The growth in incurred costs that will occur in 1988 is even more uncertain. As shown in the fourth row of Table 1, HCFA's projection for 1988 is 13 percent, but growth rates of 11 percent to 15 percent are plausible. Note that all of these values are less than the corresponding growth rates in 1987, reflecting an assumed return toward historical growth patterns subsequent to the freeze period. The fifth row in the table shows the 1988 base that would result under each of these assumptions, and the sixth row displays an adjustment to reflect interest that would be earned on the trust fund's assets during the year.

The final decision in setting the 1988 premium concerns the contingency margin--that is, what portion, if any, of the shortfall in premium receipts for 1987 should be recovered during 1988. The seventh row of Table 1 shows three possibilities: none of the projected 1987 shortfall would be recovered in 1988; based on a margin of 7 cents, about 3 percent of the shortfall would be recovered, as assumed by HCFA; and, based on a margin of 80 cents, about 25 percent would be recovered.

The upper panel of Figure 2 shows that if the low-cost projection is accurate, the announced premium of $24.80 would bring in enough income (over and above costs incurred in 1988) to recover more than the 1987 shortfall in receipts, increasing the trust fund's balance to about $9 billion and, as shown in the lower panel, raising the reserve ratio to about 11 percent. 6/ On the other hand, if HCFA's projections are accurate, the 1988 premium would do little to improve the trust fund's balance and the reserve ratio would remain negative. If the high-cost projection is accurate, the trust fund will be nearly depleted by the end of 1988.

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4. Because HCFA's current estimate of incurred costs for 1986 is nearly 7 percent higher than it was a year ago, it raises estimates of incurred costs for all future years, including 1987.

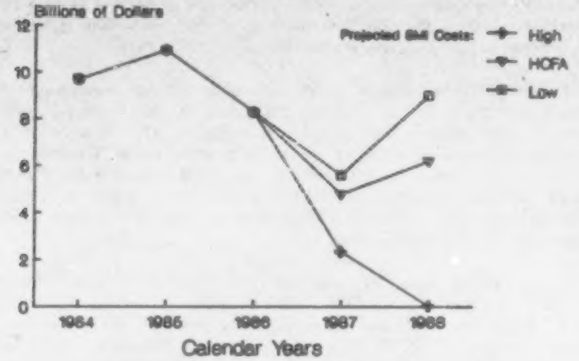
5. The range of estimates for growth in incurred costs during 1987 reflects alternative sources of information about current spending that show growth rates for SMI outlays of 19 percent to 22 percent, implying growth rates per enrollee from 17 percent to 20 percent. In addition, some of the observed growth in outlays may reflect carriers having reduced the lag between receipt of claims and payment during 1987. CBO estimates that, because of a speedup in payments, incurred costs have grown two percentage points to four percentage points more slowly than outlays.

6. The trust fund's reserve ratio is the amount of the reserve at the end of one year divided by the costs expected to be incurred in the following year.

Figure 2.

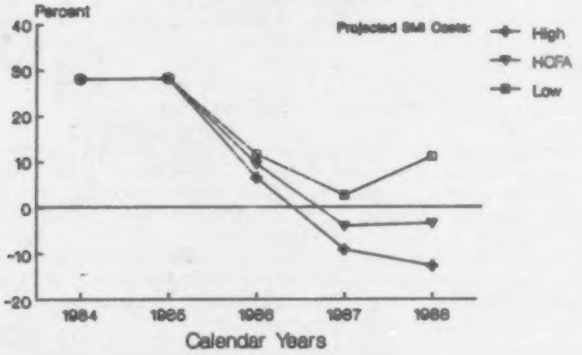
SMI Trust Fund's Balance, 1984-1988

(Assets On Hand)



SMI Trust Fund's Reserve Ratio,
1984-1988

(Reserve Over Expected Expenses)



Source: Congressional Budget Office

THE UNDERLYING CAUSES OF INCREASES IN THE COST OF SMI BENEFITS PER ENROLLEE 7/

At this point, let me explore briefly the reasons why SMI costs have grown. Higher SMI costs per enrollee are the combined result of increases in the fees paid per service (price) and increases in the quantity or intensity of services provided (volume). Historically, higher prices have accounted for more than half of the growth in costs for physicians' services, which account for 80 percent of SMI costs. Yet, higher volume was the primary reason for growth in costs during the SMI fee freeze in effect from July 1984 through December 1986.

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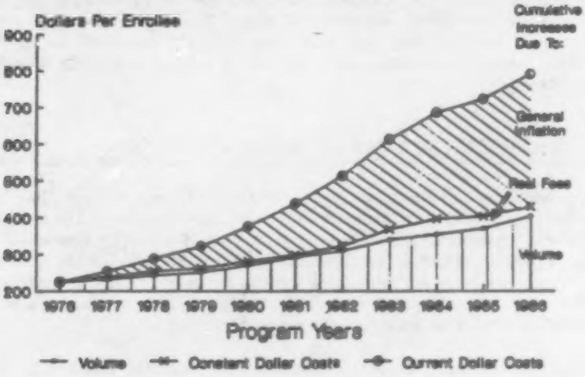
7. This section refers to program years (July through June).

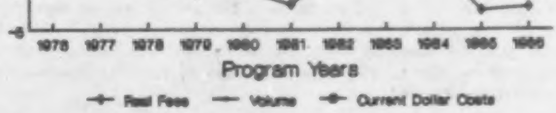
The top portion of Figure 3 shows how costs for physicians' services per aged enrollee have grown over the years from 1976 through 1986, as well as the relative importance of three contributing factors. 8/ The impact of higher prices has been divided into two parts--one that reflects general inflation as measured by the GNP deflator, which is shown by the top area; and one that represents higher real fees, which is shown by the middle area. The impact of rising volume is represented by the lowest area. Thus, the growth in costs for physicians' services that exceeds general inflation has resulted almost entirely from increases in the volume of services provided and only marginally from rising real fees.

Figure 3.

Physicians' Costs Per Enrollee, 1976-1986
(In Current and Constant Dollars)



Percentage Change in Physicians' Costs Per Enrollee, Volume, and Real Fees, 1976-1986



Source: Congressional Budget Office

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8. Costs used here are reasonable charges--that is, the amounts allowed by Medicare for covered services--and do not include any additional amounts (above the Medicare copayments) that patients may have been billed. A more detailed discussion of Figure 3 appears in the Appendix.

As the bottom portion of Figure 3 indicates, the rate of growth in volume generally increases during periods when real fees are declining. Apparently, physicians attempt to offset losses in their income that would otherwise occur by expanding services to beneficiaries more quickly in periods of constant or falling real fees than they do in periods of rising real fees. This behavior would be consistent with evidence from the period of wage-price controls in the early 1970s. That evidence indicates that physicians responded to fee constraints by increasing the services for which they billed.

It is important to bear in mind that these spikes in the growth rate for volume have occurred against a background of steady increases in services per enrollee, much of which may be desirable. For example, recent advances in medical technology have greatly expanded the ability of physicians to respond to the needs of enrollees. In addition, the need for medical services among the Medicare population has been growing slowly as the average age of enrollees has gradually risen. Finally, the decline in real fees that occurred in 1985 and 1986 has probably improved access to services for Medicare enrollees, perhaps making them more likely to seek necessary care. 9/

IMPACT ON ENROLLEES AND POSSIBLE RESPONSES 10/

With the announced premium increase, enrollees will pay $298 in 1988 for SMI premiums, or $83 more than the $215 they pay this year. The annual premium will represent 2.9 percent of median per capita income for Medicare enrollees, which is estimated to be about $10,400. Although the premium increase is small relative to income for most Medicare enrollees, it could represent a significant amount for enrollees with low incomes who are not protected by other government programs.

About 9 percent of enrollees--about 2.9 million people--will be protected because they are also eligible for Medicaid, which typically pays their SMI premiums along with most other out-of-pocket costs. Another 1.6 percent of enrollees (about 0.5 million people) will be partially protected by the "hold-harmless" provisions of P.L. 98-369, which stipulate that the dollar increase in the SMI premium for an enrollee cannot exceed the increase in Social Security benefits that the beneficiary would receive as a result of the annual cost-of-living adjustment. 11/ In other words, individuals are guaranteed that the additional amount they pay for SMI coverage will not exceed the increase in their Social Security benefits, so that at least the

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9. An additional factor is that improvements in medical technology have combined with pressures by Medicare and other insurers to shift minor procedures out of hospitals--to outpatient departments and to physicians' offices. The net effect of this shift on SMI costs is uncertain, though. Hospitals' outpatient departments would certainly receive higher SMI payments. Physicians' bills might also show some increases for certain ancillary services--such as laboratory tests--that would have been billed by the hospital if the procedures had been done in the hospital. These factors increasing SMI costs, though, would be at least partially offset by fewer physicians' bills for inpatient visits, especially given the shorter average length of stay for beneficiaries who are still hospitalized.

10. This section refers to federal fiscal years.

11. For Social Security beneficiaries, SMI premiums are deducted automatically from their monthly Social Security checks. The expected COLA increase for Social Security benefits on January 1, 1988, is 4.3 percent. Enrollees with monthly checks of less than $160 would, therefore, have partial real protection from the "hold-harmless" provision, because (0.043)($160)(12) = $83, or the amount the annual SMI premium will rise between 1987 and 1988.

nominal amounts of their checks will not be reduced. Approximately 9 percent of enrollees (2.9 million people) with per capita incomes of less than $5,000 in 1988, and an additional 15 percent (4.8 million people) with per capita incomes less than $7,500, would not be protected by Medicaid or by the hold-harmless provisions, however.

Options for 1988

If the Congress wishes to reduce the impact of the premium increase on enrollees in 1988, it has two options: it could shift costs to nonMedicare groups, or it could shift costs to Medicare enrollees in later years. In either case, the federal budget deficit for 1988 would be increased unless taxes were raised by enough to offset the costs. Furthermore, special appropriations to the SMI trust fund (in addition to the appropriations provided under current law) might be required to ensure timely payment of claims. Finally, because the new SMI premium and the Social Security COLA both go into effect in January 1988, consultations with officials of the Social Security Administration to determine the administrative feasibility of any particular option would have to begin immediately.

One possible response, proposed by Congressman Pepper in H.R. 3291, would be to limit the percentage increase in the premium to the estimated cost-of-living adjustment to be provided for 1988 Social Security benefits. In this case, the premium would rise by only 4.3 percent, to $18.70. This option would protect all Social Security recipients, regardless of their incomes, but it would raise the federal deficit by an estimated $1.7 billion in fiscal year 1988, and by $12 billion over the next five years, relative to current law. 12/

A less costly alternative would be to limit the premium increase only for enrollees with low benefits. The current hold-harmless provision could be modified to assure that each beneficiary would receive a Social Security check (net of the deduction for the new SMI premium) that was higher by at least $7 a month, or by the full amount of their COLA, whichever was lower. 13/ In 1988, this option would increase the number of enrollees who would receive some subsidy of their SMI premium from about 0.5 million enrollees with Social Security benefits of $160 or less, to nearly 7 million enrollees receiving benefits of no more than $330--a level that approximates the income guarantee provided under the federal Supplementary Security Income program. This option would raise the federal deficit by about $200 million in 1988 and by nearly $1.5 billion over the 1988-1992 period. A disadvantage stems, however, from the fact that some recipients of low Social Security benefits have sizeable incomes from other sources. Thus, about 47 percent of those who would gain from this option will have per capita incomes over $10,000 in 1988.

Options for the Long Term

A major concern about the premium increase just announced is the size of the one-year jump--more than 38 percent. Yet, because premium increases had been held down for the previous three years, the average rate of growth in the SMI premium from 1984 through 1988 is a more moderate 14 percent, closely tracking the expected average growth in costs per aged enrollee over the same period.

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12. This estimate assumes that premium increases for 1989 and thereafter will be limited by the COLA increase for the preceding year, as required under current law. If the 1988 premium increase were limited by the 1987 COLA, the premium would increase by 1.3 percent, to $18.10. This alternative would reduce federal receipts by $1.8 billion in 1988, and by $13 billion over the next five years.

13. For each affected beneficiary, the monthly subsidy of the SMI premium that would be provided in 1988 would continue at the same nominal level in future years.

It might have been better to reach the 1988 premium in more gradual steps--by having larger premium increases in the two preceding years. That approach would have required maintaining a larger trust fund reserve in 1985 and 1986 to use as a cushion for 1987 and 1988. In this light, the decision of the trustees in 1987 to reduce the expected trust fund reserve to zero, with no contingency for errors in projections, seems imprudent in retrospect.

Under current law, large one-year increases in the SMI premium are unlikely to occur in the future, because growth in the premium will be limited by the COLA beginning in 1989. But if the Congress continues each year to extend the period during which the SMI premium is set at 25 percent of costs per aged enrollee, as it has since 1984, future increases would probably be volatile.

Under the latter circumstance, volatility in the size of future SMI premium increases could be reduced over the long term by instructing the trustees to build up a larger reserve than has been their goal in recent years. This action would necessitate higher premiums, on average, than would otherwise be required over the next several years, while the surplus was being built up. Once in place, though, the trustees could use the flexibility provided by the larger reserve to dampen premium increases in periods of unusually rapidly rising costs, and then replace the reserve through higher premiums in periods of slower growth in costs.

In principle, the trustees have this flexibility now, but it was partly concern about a negative public reaction to their maintaining a large reserve that led to its rapid reduction from 1985 through 1987. Explicit instructions by the Congress to maintain a positive, but flexible, reserve could prevent such a situation in the future. For example, the Congress could provide specific guidelines regarding minimum and maximum desirable values for the trust fund's reserve.

The more fundamental solution for rapidly rising premiums, however, is to contain costs. Efforts to do so have focused only on price restraint to date, but containing costs requires placing limits on the volume of services as well. Control of both price and volume might be achieved in alternative ways, including establishing stringent utilization review programs under the current fee-for-service payment system, or introducing a capitated payment system. The issues involved are complex, however, and beyond the scope of this statement. My understanding is that testimony of the Physician Payment Review Commission will focus on this topic.

Mr. **Stark**. Ms. Gordon, are you saying that we are stuck with this increase?

Ms. **Gordon**. I am saying that it is a reasonable increase.

Mr. **Stark**. It is my feeling that our options to prevent the increase are relatively limited and I think that what you have been suggesting, is that these costs have been going up at 17 percent. Now you are saying the premiums have been going up 14 percent compounded over the past 5 years.

Ms. **Gordon**. Costs per enrollee.

Mr. **Stark**. And I am saying——

Ms. **Gordon**. I think the 17 percent comes from total costs, rather than costs per enrollee.

Mr. **Stark**. Then I am not off.

If that increase continues, we will have some huge deficit problems in the out years. If Congress does not hold to the law, the beneficiaries are going to have some huge increases over the next 2, 3, or 4 calendar years.

Ms. **Gordon**. I think that the problem for 1988 is a combination of rising costs, plus the fact that the trustees decided to run down the reserve. Estimates turned out not to be as accurate as we would like them to be, so they have to recover from what turns out to have been too low a premium in 1987.

It would be possible not to raise the premium as much this year with the intention of raising it more in future years, in order to spread out the impact on enrollees.

Mr. **Stark**. My understanding is that the baseline is now $24 and change.

Ms. **Gordon**. For purposes of the Gramm-Rudman-Hollings Act as revised, that is correct. Any premium below $24.80 would be scored as a cost.

Mr. **Stark**. I do not know why else we are here, except for the Gramm-Rudman Act as revised.

It just seems that by the time we did that, we would have to cut elsewhere in the system——

Ms. **Gordon**. The other thing to notice is that targeting under the only option that we could think of right now has to be by benefit level, which does not track income well. So if your goal was to target your assistance to those with the lowest incomes, that would be very difficult to do at such short notice before the increases go into effect. One could do it if one had time, but that would be for another year.

Mr. **Stark**. I have always said we cannot shoot the messenger. I wish it was a better message, but it was, as usual, very accurate and we appreciate the industrious approach to providing us with this information.

I hope that we can do something together in the future to hold these increases down. Mr. Daub.

Mr. **Daub**. Thank you.

In the testimony, you are indicating to us that a higher volume of physician services is the primary reason for increases in part B costs during the freeze period?

Ms. **Gordon**. If you turn to figure 3, which is on page 11 of the statement, the top portion of that figure shows physicians' costs per enrollee. We have broken out three factors that contribute to increasing costs over time. The top portion is general inflation. The next portion, shown in the clear area, is increases in fees after correcting for inflation.

Mr. **Daub**. You called them real fees.

Ms. **Gordon**. And the bottom portion is volume, shown with the vertical stripes.

Mr. **Daub**. So can you estimate what portion of this volume is inappropriate?

Ms. **Gordon**. That is extremely difficult to do, and the Congressional Budget Office would not have the capacity to do that.

Mr. **Daub**. Is it a good question to ask?

Ms. **Gordon**. It is an excellent question to ask, but you would need to involve the medical community in answering it.

Mr. **Daub**. So your general conclusion is that the estimates are valid and that the premium increase is appropriate under the circumstances that you have reviewed?

Ms. **Gordon**. That is correct.

Mr. **Gradison**. Mr. Chairman, I have no other questions.

Thank you very much.

Mr. **Stark**. Thank you very much, Ms. Gordon.

Ms. **Gordon**. Thank you, Mr. Chairman.

I appreciate the fact that you do not shoot messengers.

Mr. **Stark**. Our next witness is Dr. John Eisenberg who is a member of the Physician Payment Review Commission, fondly referred to as PhysPRC. He is accompanied by Dr. Paul Ginsburg, who is the executive director of PhysPRC.

Gentlemen, welcome to the committee. As I recall some months ago, you got us in quite a bit of trouble with the AMA for suggesting cuts in overpriced procedures. I am curious to see what kind of trouble you are going to get us into today. We look forward to your testimony and you can proceed in whatever manner you are comfortable.

STATEMENT OF JOHN M. EISENBERG, M.D., M.B.A., COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL GINSBURG, PH.D., EXECUTIVE DIRECTOR

Dr. **Eisenberg**. Thank you, Mr. Chairman.

We share with the Congress and this committee concern about the increasing cost of medical care and particularly that of part B and we recognize, as does the committee, that this is the latest manifestation in a long-term trend of increasing costs of medical care.

We believe, as has been said during this hearing today, that we need to understand the reasons for this increase in costs, one of which is related to increasing services rendered by physicians.

The work of our commission has followed two tracks. One has addressed the pattern of relative payments to physicians which we believe provides, in its current fashion, distorted signals to doctors about how they ought to practice, which services they should provide to their patients, where they should practice and what specialties they should enter.

We have recommended to the Congress a fee schedule which we believe is the proper approach for us to take in the future years. We believe that any interim changes in physician payment should be consistent with that long term goal of seeking a fee schedule.

We believe that a fee schedule can help us by diminishing some of the incentives that are inappropriate in the current charge based system of paying physicians. However, we recognize that a fee for service system of paying physicians has, intrinsic in it, an incentive for physicians to do more for their patients since doing more enhances the income of the provider.

So the second track that we are taking as a commission is that of addressing the volume of the services that are rendered, the issue that has been addressed by some of the people who have come before you today.

In fact, we have been reinforced in our desire to address that issue by you and Congressman Gradison in your urging to the commission to make this a high priority of the commission's activities. And we are doing so.

We believe that there are several policy directions that the Congress might take in addressing the problem of the volume of services rendered to Medicare beneficiaries, and I would like to outline them.

All of them have at their root one principle. That is that physicians and beneficiaries together should selectively reduce those services that are least important to a patient's health. Given that principle, we believe that we should start by improving our ability to distinguish those services that improve a patient's outcome from those that do not.

There are large gaps in our knowledge today and there is not much money being spent on technology assessment or other mechanisms to determine which services are valuable and which services are not valuable for physicians to provide to their patients. We need, therefore, to address the problem of distinguishing useful services from those that are either less useful or not useful at all.

In doing so, we believe that a second step must be taken, and that is to involve the medical community in this effort. Professional efforts, such as the American College of Physicians' program to develop guidelines for physicians for a more effective and efficient use of common tests is an example of a way in which the profession might be enjoined to work together with us to provide more cost effective care.

In addition, clinical scientists who investigate these sorts of subjects should be encouraged to assess the cost effectiveness of medical services that we provide, perhaps with the support of the National Center for Health Services Research and the Health Care Financing Administration.

We believe that this kind of information can help guide physicians who otherwise might be left in the dark in trying to determine which services, in which circumstances, will benefit their patients most.

I would like to pause here and reflect on an ethical dilemma for physicians. I think independent of the amount of money that a physician receives for services provided, the physician believes that he or she is the patient's advocate, and in that regard should provide every service that is of any marginal value in improving the health of that patient.

On the other hand, physicians believe that they are and should be conscious representatives of society, and in that regard should use only those services that are cost effective. Those two roles of the physician are sometimes in conflict.

Unless we provide physicians guidelines about how to make those decisions, they will, more than they might otherwise, be guided by financial incentives.

We believe that the Commission, in its efforts, should encourage the application of this knowledge to the physician's practice through mechanisms such as education, utilization review and financial incentives, maybe even financial penalties to help physicians act upon the best information that is available today.

We believe that the commission should continue to investigate the possibility that capitation might be a mechanism to encourage physicians to provide the most cost effective care, but we are concerned about two issues. First, the method by which the capitation payment is calculated, and second, the flip side of the incentives for physicians in the fee for service system to provide too much care, or specifically, the intrinsic incentives in capitation to provide perhaps too little care.

We believe that an incentive neutral system should be sought, that neither fee for service nor capitation has intrinsic in it an incentive neutral payment mechanism for physicians.

We would like to remind the Congress that the savings that have taken place in HMOs in the past have, by and large, been savings that have occurred because of decreased hospitalization, sometimes with increased utilization on the outpatient side. So, that we believe that a capitation system of paying physicians might not solve the problem we are addressing today, which are the increases in part B expenditures, although they might help to address the problem of payments on the hospital side.

In addition to these mechanisms, we should explore the coding that is used by physicians for the receipt of payment for services to Medicare beneficiaries so that we can reduce opportunities for abusive billing practices. We believe that we should explore the responsibility of beneficiaries to share in the cost of their medical care and the degree to which their role can help to reduce unnecessary services.

We should explore the degree to which malpractice fears might increase some defensive medicine practices, and we should investigate how the supply of medical practitioners influences the volume of care provided.

The Commission has endorsed a fee schedule for Medicare. We believe that the fee schedule, if properly constructed, can help us to reduce incentives for inappropriate care. But we believe that the volume issue we are addressing today will remain an important one and we will, in the months to come, investigate this subject with great intensity. We hope we can come back to the Congress as the Commission's work proceeds with some specific recommendations to address the problem of the volume of services to Medicare beneficiaries.

Thank you.

[The statement of Dr. Eisenberg follows:]

Statement of the Physician Payment Review Commission

Before the
Committee on Ways and Means
U.S. House of Representatives

John M. Eisenberg, M.D., M.B.A.
Commissioner

September 30, 1987

I am John M. Eisenberg, M.D., member of the Physician Payment Review Commission, and I am accompanied today by Paul B. Ginsburg, Ph.D., who is Executive Director of the Commission.

The enormous premium increase that has been announced for Medicare Part B is the latest manifestation of long-term trends of rapidly increasing outlays in this program. These increases, which are far in excess of the rate of inflation, have imposed substantial burdens on both Medicare beneficiaries and the nation's taxpayers, who now foot 25 percent and 75 percent respectively of the federal bill for this program. The Physician Payment Review Commission has serious concerns about these trends, and is working to develop carefully considered options to recommend to the Congress.

TRENDS IN OUTLAYS FOR PART B

At the last meeting of the Commission, its staff presented data on trends in Part B outlays over the 1975-1985 period. Of the 16 percent per year average annual increase, increasing numbers of enrollees accounted for 2 percentage points, higher prices accounted for 7 percentage points, and more services per enrollee accounted for 7 percentage points. Over the ten-year period, services per enrollee almost doubled.

It is too early to know whether the data reported for 1986 and 1987 indicate an acceleration of the growth in services per enrollee. But at minimum, the data indicate that past years' high rates of growth are continuing. The data and associated premium increase reinforce our conviction that we must consider how to address the growth of volume in medical services provided through Part B.

As we review the data before us and consider options that affect the utilization of services, we must be cautious about the interpretation of the increases we see. There are multiple factors affecting the quantity of services provided. Some of the increase in services reflects a reduction in unmet needs or new or improved capabilities to provide needed care. Some is the result of policies adopted deliberately to improve access to care (e.g., incentives for physicians to become participating physicians). But some undoubtedly reflects an increase in services that do not help patients significantly. It will be difficult to distinguish between volume increases resulting from the provision of important additional services to patients and those reflecting services of little or no value to patients.

Both physicians and beneficiaries play important roles in determining the volume of medical services provided. Physicians, as agents of their patients, render professional judgments regarding the use of medical services, including their own services. They are expected to provide all services of benefit to their patients. But, physicians also have a financial incentive to provide more of all services. The potential for physicians to adjust the number and mix of services they provide in response to such an incentive has led to concern.

There is some evidence in the research literature that physicians have responded to fee constraints by providing additional services. Some of the increase in utilization we are now trying to explain may reflect physicians' response to recent increased economic pressures on their practices. The 1984 freeze in physician fees, the continuing effects of the Medicare Economic Index (MEI) in constraining prevailing charges and the introduction of the Maximum Allowable Actual Charge (MAAC) to restrict increases in actual charges for physicians who do not accept assignment are all examples of policies that have contributed to a changing economic environment for physicians.

The increase in physician supply, particularly in the past ten years, would have been expected to increase the quantity of services provided simply as a result of its improving the availability of services. Since the growth in the number of physicians per capita also results in smaller patient loads on average, however, the question arises as to whether physicians may have responded to increased competition for patients, in part, by increasing the number of services per patient.

In some cases, what appears in the data as increased utilization of services by Medicare beneficiaries may in fact result from changes in the ways physicians bill for services. Billing separately for services that previously had been billed as part of a single package (e.g., office laboratory tests associated with an office visit, such as urinalysis or test for occult blood) will appear to increase the quantity of services provided. While the actual quantity of services may remain unchanged, such "unbundling" of services often leads to higher expenditures, because the sum of the payments for the individual services may amount to more than the single payment for the service package. Both the reporting of services and expenditures can be affected as well by "upcoding." Where coding systems present a range of services that may be close substitutes, physicians have incentives either to bill under the code that generates the highest approved charge or to provide more complex (and more expensive) services than they would otherwise have considered appropriate treatment.
Beneficiary demand for care also has contributed to the increased use of services. Access to physicians probably has improved with the increase in physician supply, making it easier for beneficiaries to obtain physician services. Moreover, financial barriers to care may have been reduced in recent years through the combined effect of the freeze on physician fees and increases in assignment rates.

Increased media coverage of advances in medical technology and procedures also may encourage patients to demand more care from their physicians. Consumer awareness of the technology available to detect and remove malignant lesions in the colon provides the most likely explanation for the 50 percent increase in the number of colonoscopies in the period immediately following President Reagan's well-publicized surgery.[1]

Beneficiaries seek the services they think will meet their medical needs. Their demand will be tempered by out-of-pocket costs associated with that care. Medicare and supplementary coverage, however, insulate them from much of the cost of the services they receive. Decisions about the use of any service that is perceived to have some potential benefit, thus, will be influenced not only by the positive financial incentive to physicians to provide the service but by the weak financial incentive for beneficiaries to restrict their use of services.

Among the factors often suggested to explain the increase in use of services by Medicare beneficiaries is the aging of the population. Not only is the elderly population growing, but the elderly as a group are aging. While the growth in the elderly population contributes to growth in Part B outlays to some extent, the aging of the elderly population has only a minor effect on the growth in services per enrollee. The older elderly do use services at a higher rate than Medicare enrollees in general, but the Medicare population is not aging rapidly enough to make a major contribution to the nearly 7 percent annual increase in services per enrollee.[2]

Changes in medical technology lead to changes in the practice of medicine that have implications for the numbers and types of services provided under Part B of Medicare. New equipment or techniques enhance physicians' ability to respond to the medical needs of the elderly population. Advances in medical technology can affect utilization either by adding new services and equipment or by substituting for other services. Innovations that reduce risk, discomfort, and inconvenience for the patient are likely to be used more frequently than their predecessors. Moreover, refinements in technology may lead to more specialized applications that increase the overall number of procedures performed for a given condition.

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[1] Preliminary results from a study by Peter McMenamin and Howard West of Circle, Inc., reported in the American Medical News, September 18, 1987.

[2] The number of SMI enrollees is growing about 2 percent per year. Our calculations indicate that the aging of this population contributes only 0.1 percent per year to growth in SMI outlays.

Advances in both surgical techniques and anesthesia have made it possible to move procedures traditionally performed in the hospital to outpatient sites. Medicare prospective payment for inpatient hospital services also has moved some services previously performed while patients were hospitalized to outpatient settings because of the incentives for preadmission testing and earlier discharge of hospital patients. These shifts from inpatient to outpatient care are reflected in increased service volume and increased expenditures under Part B of Medicare. The shift is less relevant for physician services than for nonphysician services covered under Part B, such as hospital outpatient departments and durable medical equipment, since physician services within the hospital have always been covered under Part B. While the movement of hospital services to outpatient settings has led to increases in Part B expenditures, it has probably reduced overall Medicare costs. But it also has shifted costs to beneficiaries, including costs for some services covered only as inpatient services (e.g., prescription drugs), increased copayments, and increased premium costs required to cover 25 percent of Part B program expenditures.

WORK OF THE COMMISSION

In its work to reform physician payment in the Medicare program, the Commission has followed two tracks. One has focused on the pattern of relative payments for physicians' services. The current pattern of variation in payment among services and among geographic areas is not a rational one.[3] It gives distorted signals to physicians concerning how to practice, what specialty to train for, and where to locate. The pattern of payment also creates inequities among physicians and the beneficiaries they serve. To deal with these problems in pricing of physicians' services, the Commission is in the process of developing a fee schedule, and has recommended to this Committee that interim changes in Medicare physician payment alter relative prices towards the pattern likely to be adopted as part of a fee schedule.[4]

The Commission anticipates that adoption of a fee schedule would slow the rising volume of physician services through more appropriate incentives. Reducing fees that are too high will diminish the financial incentive to provide too many of these services. However, a fee schedule alone would not be sufficient to contain costs as much as needed. We have only limited information with which to predict the degree to which the use of individual services would respond to changes in relative prices. We do not know whether the savings from reduced use of those services whose relative values are lowered would be offset by increased use of those services whose relative values have increased. In addition, fee schedules keep intact fee-for-service incentives in which doing more for patients enhances the income of the provider.

For this reason, the Commission is pursuing a second track concerning policies to contain increases in the volume of services per enrollee. While planned from the beginning, this work began in earnest over the summer, and a substantial portion of the Commission's agenda will be devoted to it for the foreseeable future.

The importance of this work has been underscored by your health subcommittee. In May of this year, Congressmen Stark and Gradison asked us to put a top priority on policies to control the rapid growth in the use of physician services. They also noted that it is a "tall order" to come up with effective policies that neither threaten financial protection for Medicare beneficiaries nor compromise their access to needed health care.

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[3] The Commission's first annual report to Congress in March, 1987, is a source of additional information on the problems of the current system of payment and options for reform: Physician Payment Review Commission, *Medicare Physician Payment: An Agenda for Reform*, Government Printing Office, Washington, DC, March 1987.

[4] Statement of Philip R. Lee, M.D., Chairman, Physician Payment Review Commission, before the Subcommittee on Health, Committee on Ways and Means, June 15, 1987.

To begin its work on the volume of services, the Commission has solicited the advice of medical organizations, consumer groups, and others. The initial response has been constructive and encouraging. We will also draw upon the work of several agencies of the government, including the Health Care Financing Administration (HCFA), the General Accounting Office (GAO), and the Office of the Inspector General (IG).

The need to slow the increase in the costs of the Medicare program is critical. Nevertheless, despite the importance of the need to contain costs, the Commission will not recommend solutions that would cause undue hardship for beneficiaries. Medicare was created to provide access to good quality health care to its beneficiaries, and to cushion the financial consequences of ill health. As the Commission stated in its first report to Congress, these objectives should not be sacrificed.

POLICY DIRECTIONS

The task, then, is to reduce costs without inadvertently compromising access and quality of care. This will require that physicians and beneficiaries selectively reduce those services that are least important to patients' health. The policy options that the Commission will consider offer several different mechanisms aimed at encouraging beneficiaries to demand and physicians to provide only services that are of significant medical benefit. These options range from physician education, to utilization review, to the use of financial incentives. It is likely that a combination of these options will be required.

The success of these efforts will depend on the ability to distinguish services that improve patient outcomes from those that provide little or no medical benefit (or even risk harm to the patient). To do this, both physicians and beneficiaries will need better information on the effectiveness of medical services.[8]

There are large gaps in our knowledge of the effectiveness of medical services, and of the best ways to care for patients. Only limited resources have been devoted to research on determinants of patient outcomes and costs of care.

While additional clinical research is needed, much more could be done within the limits of current medical knowledge. Studies have shown that there is considerable variation in medical practice across geographic areas, across delivery systems, and across individual physicians. They suggest the provision of substantial amounts of unnecessary services. They lead us to believe that there is considerable potential for reducing the use of unnecessary services without compromising the quality of care. Involvement of the medical community is critical for success of this effort.

Recent work demonstrates how physicians can develop guidelines for appropriate use of services and optimal care of patients. For example, the American College of Physicians and the Blue Cross and Blue Shield Association have cooperated in the development of guidelines for the use of common diagnostic tests. The American College of Physicians, through its Clinical Efficacy Assessment Project, has developed guidelines for appropriate use of services, such as endoscopy in patients with dyspepsia, and appropriate care of patients with selected conditions including cholecystitis and diabetes. The Health Services Utilization Study by the RAND Corporation has used expert consensus to develop appropriate indications for use of coronary angiography, upper GI endoscopy, and carotid endarterectomy. The American Medical Association's Diagnostic and Therapeutic Technology Assessment (DATTA) project uses panels of expert physicians to address questions of safety and efficacy of medical technologies.

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[8] Physicians and patients jointly determine what services are used in the patients' care. Since physicians usually have a better understanding of the effectiveness of services, they often play the greater role in the selection of services. This discussion is focused more on improving information available to the physician, but applies to both physician and patient.

Such programs can develop sound, practical, and credible standards or guidelines based on the consensus of medical experts after thorough review of available medical literature. These guidelines for appropriate use of services can provide the basis for both programs to educate physicians and beneficiaries and for utilization review activities. With additional resources, this process could be used to develop guidelines for other procedures and for care of a greater variety of patient problems. This process is not without cost. However, investment of a small fraction of the annual expenditures for Medicare could yield substantial returns in more cost-effective care.[6]

With more information about which services really improve patients' outcomes, physicians and beneficiaries will be in a better position to judge the merits of services, particularly those that now fall into a grey area--their medical value is uncertain but probably very small. Given fee-for-service incentives that encourage the physician to do all that might benefit the patient and fears of malpractice suits, better information on what services are of little or no benefit will need to be in the physician's hands if services in this grey area are to be significantly reduced.

Physician Education

Information cannot be expected to affect the provision of services unless it is systematically disseminated to physicians. Many in the physician community believe that most physicians will alter their practices if they are informed that their practices do not conform to standards developed by expert physicians in their own field of medicine. Information on appropriate use of services can be made available to physicians through educational programs that emphasize expert standards for care, such as those developed by the American College of Physicians and the Blue Cross and Blue Shield Association, or provide physicians with direct comparisons of their practice patterns with those of their peers.

One example of the latter type of program is the Maine Medical Society's sponsorship of the Maine Medical Assessment Project to inform physicians how their use of specific services compares with their peers in the state. This appears to have led to reductions the targeted services in areas of high use.

The Commission is reviewing examples of programs to educate physicians and beneficiaries using specific guidelines for appropriate care, such as those for common diagnostic tests and endoscopy. It will assess the potential of these programs to improve the cost effectiveness of care provided to Medicare beneficiaries.

Utilization and Quality Review

Review of utilization of services is performed by Medicare carriers and by Peer Review Organizations (PROs). The review of utilization is based on rules that are intended to identify unnecessary services and either dissuade the physician from providing them or deny payment for them. PROs have also begun to evaluate quality of care.

The Commission has begun to study programs of utilization and quality review used by carriers, PROs, and the private sector. Drawing on studies by HCFA, GAO, and the HHS Inspector General, we will examine alternative mechanisms to improve the effectiveness of carrier and PRO medical review. For instance, how cost effective are the utilization and quality screens used to select cases for physician review? PROs now focus on inpatient care, though a substantial amount of care has shifted from the hospital to outpatient settings, where there is less review of use of services and their quality. We will consider whether PRO or similar review should be expanded to incorporate care in outpatient settings.

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[6] The clinical research described here has been carried out by several investigators. Some has been sponsored by professional societies. It has been supported by a variety of sources including the National Center for Health Services Research and Health Care Technology Assessment, the Health Care Financing Administration, the Blue Cross Association, and several private foundations.

We are particularly interested in how well these programs incorporate current medical knowledge of the appropriateness of services. Utilization screens and conditions for prior approval of admission or a procedure would be more easily accepted if they were based on credible standards developed by peers. For example, a physician's reason for doing a planned coronary angiography could be compared to accepted indications for that procedure developed through expert consensus.[7]

Financial Incentives

The Commission also plans to consider various methods that emphasize the use of financial incentives to physicians and patients. For physicians, these range from mechanisms that alter the incentives of individual physicians to prescribe services to those encouraging broad groups of physicians to practice in a less-costly style. An example of the former approach is increased use of procedure packaging. Traditionally, surgery has been paid for on the basis of a global fee--a fee that encompasses the major surgical procedure, ancillary procedures by the surgeon, and post-operative visits by the surgeon. The global fee approach could be extended to non-surgical procedures by including the associated office or hospital visit with procedures such as colonoscopies.

Physicians charge for a number of services that they do not personally perform, such as diagnostic tests. If the physician is allowed to charge the patient more than the cost of the test, there is a financial incentive to order such tests. Congress has attempted to limit this practice for clinical laboratory tests. The Commission will examine whether this approach should be extended to similar services.

At the opposite end of the spectrum, Medicare allowed fees in an area could be based in part on the use of services by all physicians in the area. For instance, the prevailing charge for each service could be reduced if total expenditures in the area exceeded a budget target, or increased if expenditures were below a target. A policy of this type has been is used in West Germany. While it would not appreciably alter financial incentives to individual physicians, it could encourage more vigorous actions on the part of the physician community to support peer review activities and educate their members on appropriate medical practice.

The Commission will also examine the effectiveness of financial incentives for beneficiary use of services. For instance, do copayments selectively reduce the use of unnecessary services, or do they reduce access to needed services?

Capitation

Since Congress made a key decision in 1982 to authorize Medicare to offer a more attractive risk contract to HMOs, capitation has become an option for a significant number of beneficiaries. The research literature indicates that HMOs can reduce the use of services, especially hospital services, by a substantial amount. The Commission has begun to examine a number of issues pertaining to capitation by HMOs in Medicare. It plans to look into revising the method by which capitation payments are calculated. It will study the appropriateness of policies by HMOs to limit use of services by enrollees, including certain types of incentive contracts between HMOs and physicians. It will assess whether the definition of a "qualified" health plan should be changed.

The ultimate role that capitation will play in the Medicare program is not yet known. Policy decisions that are made now will have some bearing, but the ability of HMOs and other private health plans to contain costs, and the acceptability of these plans to Medicare beneficiaries, will be the key considerations.

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[7] Such guidelines or standards must be applied thoughtfully and flexibly. No set of standards can specify exactly what should be done for every patient. Their application must take account of variations in the clinical situation. Rigid application of guidelines, such as using them as ceilings on services deemed to be appropriate for all patients in a category, could reduce the quality of care and will compromise the effectiveness of the utilization program itself.

Billing Practices

Evidence of changes in billing practices by physicians that contribute to increases in Medicare outlays is mostly anecdotal, but prudent management requires substantial efforts to uncover and prevent improper billing practices. Many physicians have expressed to the Commission their concerns about billing practices of some of their peers. Part of the Commission's work to develop a fee schedule concerns the coding of medical procedures for payment purposes. For example, the Commission is testing the use of consensus panels to consider whether closely-related services should be paid the same amount and to clarify and standardize definitions of what is included in surgical global fees. This could facilitate carrier review activities.

Physician Supply and Tort Reform

A part of the solution to rising outlays for physicians' services may lie outside of reform in payment methods. While beyond the Commission's mandate, policies concerning physician supply and medical malpractice could well be part of the solution to the problem of containing the costs of physicians' services.

CONCLUSION

Medicare has provided the elderly and the disabled access to medical care of high quality while protecting them from financial hardship. Continued rapid increases in the volume of services are making this accomplishment increasingly difficult for beneficiaries and taxpayers to underwrite. Given the evidence that some of these services have little medical benefit to the patient, we can contain costs without sacrificing the goals of Medicare by designing policies that will inform physicians and patients which services these are and induce them to forego them. This will not be an easy task, but one that must be done.

Mr. **Stark**. Thank you. That was good timing.

You have raised in your testimony a suggestion that I think is unique and I want to see if I can expand on it a little further and see if I understand it.

I suppose we could say that if the law now requires that we limit the increase in 1989 to the cost of living adjustment for Social Security, the simple and budget neutral answer to that would be swell. Let us assume that it is going to be 4 percent.

Let us just say that all we are going to do is pay part B reimbursement to providers no more than 4 percent over the previous year. That is very easy to say, but I suspect it is difficult to figure out how to limit it.

What you are suggesting on page 14 is kind of a microcosm of that, example. You are suggesting that we could take an area, for example, the District of Columbia, and assume that the Medicare approved rate for a simple x ray is $5. If we take last year's x rays and assuming that we have no new beneficiaries we are going to pay the same amount next year for x rays.

If the volume of x rays goes up we are going to cut the rate from $5 to $4.80 for an x ray, so that in effect we have a cap on that particular service for a given area. You are also suggesting in your testimony that if the volume of x rays is kept down we might pay $5.20 in x rays. So there is some incentive in the x ray technicians community to try and stay within that limit.

Is that a fair interpretation of what you are suggesting on page 14?

Dr. **Eisenberg**. That is a fair summary of what we are getting at. We have not, as a commission, explored this option but we understand that it is used in other systems of paying physicians and we believe that we ought to explore it, investigate its advantages and disadvantages, and present those to the Congress.

Mr. **Stark**. Is that something that could be imposed on the medical providers unilaterally? In other words, could you conceive of that option working without the cooperation of the physicians involved?

Dr. **Eisenberg**. No, I think that physicians, either as an organized body or as individuals are going to need to participate and cooperate in a system like that. There are certainly mechanisms whereby physicians could game a payment system like this, just as you said earlier, they game the current fee for service system.

This might pit one physician against another. If there is a fixed pot of money available to be used, physicians would compete against each other, to try to get as much of that pot for themselves and their patients as they can.

It is going to require a lot of cooperation from the profession.

Mr. **Stark**. Could you suggest any way that HCFA, as directed by the Congress, could hold down or control the Medicare part B services if, in fact, the providers of those services routinely refused to negotiate with either HCFA or Congress? We are faced with that dilemma now. Basically the AMA will not tolerate any of the subspecialties negotiating with you. They will fight you politically and they usually win.

Could you suggest a way that we could efficiently and without harming the beneficiaries have some kind of cost constraints over part B services?

Dr. **Eisenberg**. Without cooperation from the profession? As a member of that profession, I would not want to see the process evolve in that direction.

Mr. **Stark**. As a Member of Congress, I want to see it even less than you do.

Dr. **Eisenberg**. I believe that the two groups, Congress and the medical community, can work together to find mechanisms that are acceptable to both through education of physicians, through utilization review, that involves physicians in the review and in setting the guidelines for that review. In these ways a collaborative and cooperative mechanism could be established.

I think you are right, that if both parties decide this is an adversarial relationship and deal with it as such, it will probably be a self-fulfilling prophecy and the two groups will not work together, we will be working at odds. I would much rather see us work together.

Mr. **Stark**. But the question was what could you suggest that would be the most efficient way if we are going to obey the law? If I am correct, the administration has recommended freezing fees. Since I have chaired this subcommittee, we have recommended fee freezing.

Let us suppose that next year we are going to hold part B increases to the COLA, and suppose the COLA is 4 percent. If we have the same budget constraints that we now have, how do we limit part B reimbursement at 4 percent?

If we have to do that unilaterally, what direction do we take?

Dr. **Eisenberg**. I do not think, with the current system that we have of fee for service payment, that we can prospectively prescribe exactly the amount of increase that we are going to have, because the volume of services is not within our control. The only way we could predict ahead of time exactly how much we will be spending would be to have a major change in the way in which we pay physicians.

It could be by establishing guidelines for the total amount that will be spent. As you referred to earlier there is the model sometimes referred to as the German model, where physicians have a fixed amount that can be spent and that money is divvied up among them based on the volume of services they provide.

I do not think, though, that there is a way other than fixed budgets or capitation, that we could prospectively establish how much is going to be spent in a given year.

Perhaps Dr. Ginsburg would like to elaborate on that further.

Mr. **Ginsburg**. The only point I would like to make is that we have had this problem of rapidly rising outlays for many years, and we are going to face it for many years into the future. We have to be careful that the pressures of a given year do not cause us to use an approach that would poison the possibilities for more effective changes in the future.

I know time is running out, but I would hope that we could avoid using a meat-ax approach very soon. I believe there are changes that do have potential that can be put in motion quite soon.

Mr. Stark. I share your concern because, as I have said so often, Congress generally does not dream up these approaches. In Congress we deal with budget constraints, get recommendations from HCFA, act on them and increase them or decrease them, but when an attempt is made to follow the recommendations of your Commission, we get into a political contest and usually lose.

But when the public decides that enough is enough, Congress may react very quickly and without much deliberation. If we start to get the same pressure from the beneficiaries, our constituents, that we get from the ophthamologists, and I would submit that each of us has more Medicare beneficiaries in our district than we have ophthamologists, we might just decide to take the lowest rate charged for cataract surgery anywhere in the country and set that rate as the maximum.

It would probably not be the right solution, but I can foresee a public outcry of that magnitude. When the public puts pressure on, then Congress does react and often reacts with limited information, limited time and in ways that are sometimes not very efficient.

We are going to have this problem next year. The funds are going to have to come out of the general revenues or it cannot exceed, or the law will have to be changed, which would be a tough vote. It would be a tough vote to say that the Medicare premium is going to increase by more than 4 percent when a physician's income is going up indiscriminantly.

If the premium goes up 13 or 14 percent, that is a politically tough problem. When we are faced with that problem, general revenues will be hit for funds. The easy solution is to just let general revenues pick up the deficit in part B, but I am not sure how long that can continue.

Would you outline for the record, Dr. Eisenberg, the recommendations that the Physician Payment Review Commission (PhysPRC) made to this committee regarding certain surgical procedures that were considered overpriced.

Dr. Eisenberg. That is correct.

Mr. Stark. This recommendation was not originally the committee's suggestion. I recall, along with the ranking member, a deep concern that this committee did not want to decide which medical procedures were overpriced, because we would not have any idea where to begin and most of us cannot spell the procedures that you outlined for reimbursement cuts.

Could you just summarize once more, in general terms what your Commission decided? How did they determine which procedures, whether it was heart surgery or eye surgery, were overpriced? And then, in layman's terms, recommend them to us.

Dr. Eisenberg. First, let me say that what we did was to look at which services are relatively overpriced. Using an index of three procedures provided to Medicare beneficiaries, we compared the relative amounts that were paid by Medicare to physicians for a list of procedures with the relative amounts that were paid to physicians by other payers whose decisions on what to pay were based on factors other than traditional or historical charges.

Comparing the relative values implicit in the different payment schedules with the relative values of Medicare procedures, it turned out that there were several services for which Medicare paid more relative to the index procedures than any other system. It was for those services that we felt we could conclude that Medicare was probably paying relatively more than it needed to pay.

Mr. STARK. So you were really looking at the free market, is that correct?

Dr. EISENBERG. In some cases, it approached the free market. I would not pretend to say that these other systems use the free market, but they were often based upon more competitively based systems of payment than the historical charges upon which Medicare is based.

Mr. GINSBURG. If I could add something about the relative value scales chosen, these were scales that have some of the characteristics that the Commission ultimately envisions for a Medicare relative value scale. We looked for those that had a link to the resource costs of providing the service and that had significant technical input from physicians.

So, in a sense, we saw them as the pioneers that we were following, rather than being where most of the market is.

Mr. STARK. If I recall correctly, if we had followed your recommendations, Medicare would not necessarily have been the lowest payer for those services in any part of the country, is that correct?

Mr. GINSBURG. Yes, for each of those services, the range of reduction that this committee and the Energy and Commerce Committee considered was much lower than what this methodology would have implied.

Mr. STARK. As I recall, lower than what the administration recommended.

Mr. GINSBURG. With the exception of cataract surgery, I do not think the administration made recommendations this year on procedures.

Mr. STARK. Sandy Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

Let me just ask you what the bottom line is.

Dr. EISENBERG. The bottom line is the highest quality care for the elderly with the greatest access to needed care and a cost that is affordable.

Mr. LEVIN. That principle really does not have any meaning for this week or next. That is what we are here to discuss. I think your bottom line works out, we essentially do nothing now.

Dr. EISENBERG. Our bottom line is as follows: the commission first dealt with the issue of prices, relative prices and how they ought to be established for the payment of services to Medicare beneficiaries. The Commission reported to the Congress and recommended a fee schedule.

Then, at our last meeting, we made clear that while the Commission will continue to work in that area, simultaneously we need to start to work in the area of volume, decreasing inappropriate use of services.

Mr. LEVIN. Right. But what do we do now, though? I mean, we have a recommended increase. You have pinpointed an area of difficulty in an area of some abuse and yet you are saying to us you are not quite sure how much abuse and we need to study it.

Dr. EISENBERG. We are saying that we need to evaluate the different mechanisms to limit those services being provided to beneficiaries which may be of no value or of marginal value. We expect to provide the Congress with advice about how it can determine the degree to which services of marginal value—some value to the patient, but not as much as some other services—can be determined, how many of those services we can afford to pay for, and how will we provide the physicians with incentives to limit these services.

Mr. **Levin**. I understand. What do we do next week or this week?

Mr. **Ginsburg**. I do not think that there is any doubt on the part of the Commission that steps need to be taken to slow the increase in outlays in this program. I do not think the Commission is calling for studying whether we have a problem.

Mr. **Levin**. I know that. You tell us we have a problem, but we know that. I mean, we are glad to have your advice on that, but the testimony earlier by HCFA made it clear, though we are not sure of the problem, the magnitude. On the one hand, we do not want to be arbitrary or be premature. You made a plea, do not do anything prematurely because you may, we may prevent—we may poison the well.

But essentially, if that is all you say to us, it is a message for now of inaction, of accepting of this increase. I mean, that is what it is. I think you need to boil down all of the language, as we have to, to voting, proposing. I think this picks up the chairman's question, that is, is there anything on an interim basis that you might suggest in terms of control of physician charges of the volume? Is there anything we should do, or can do?

Dr. **Eisenberg**. The Commission obviously serves at your pleasure. And we understand that your pleasure is that we address the issue of volume with intensity, and we intend to do so. I believe that it is premature to say that the Commission can make specific recommendations about what should be done today or tomorrow.

I think it is also fair to say though, that the Commission is encouraged by the prospects of educating physicians, encouraged by the prospects of utilization review, encouraged by the prospects that we may be able to develop a fee schedule that could remove some of the inappropriate incentives that increase volume, and encouraged by the prospects of changing the coding used in billing for medical services that will decrease the potential for "gaming" the system, as the term was used earlier.

I think it is fair to say that we would encourage the Congress to consider all four of those interventions now. And in our next meeting we will consider them in more depth and come back with more concrete recommendations to you in the future.

Mr. **Levin**. You say to consider them now? You mean, consider implementing any one of these right now?

Dr. **Eisenberg**. It is appropriate for the Congress to consider mechanisms to encourage the increased education of physicians, the increased determination of services that are appropriate and inappropriate, and to review the degree of appropriateness of services rendered. It is appropriate for the Congress to consider now reform of the procedure coding for Medicare billing. And it is appropriate for Congress to consider ways in which the fee structure can be changed to diminish the incentives for inappropriate services.

Mr. **Levin**. But what does that all mean in action terms?

Dr. **Eisenberg**. Let me give you some——

Mr. **Levin**. I mean, we are essentially at that point, it seems to me. I do not want you to go beyond your ability to commit yourself at this point, and I do not think the committee wants to be arbitrary. If there are ways to proceed reasonably, even if tentatively, we, I think, want to consider that. Especially if all this waits until next year until all the studies are done, when we bump up against the COLA maximum, we are not going to have any further experience under our belt, you see?

And I do not see coming so far out of our discussion here this morning and early this afternoon, some concrete ideas that members of Congress could incorporate into a bill within the next several days for implementation in fiscal year 1988.

Dr. **Eisenberg**. I think we all agree that some services may be of no value and some services are of marginal value when——

Mr. **Levin**. How do we begin—what can we do on an interim that would separate better the wheat from the chaff?

Dr. **Eisenberg**. The first thing that we could do is to provide mechanisms whereby the profession could be educated about what is wheat and what is chaff, at least what is currently known about what is wheat and what is chaff. Other mechanisms could focus on educating beneficiaries, so that they can work together with their physicians to choose the most effective services.

And I think we could start tomorrow to identify additional information about what is wheat and what is chaff, so that the day after tomorrow we will have that additional information to provide to physicians. That is voluntary. That allows physicians and patients to use the best knowledge available to select the services of most value. And I think we could do that immediately.

Mr. **Levin**. I do not think there would be much sanguine feeling that that would save much money. I do not think CBO would cost that out in terms of savings as anything beyond zero. I mean, that is what we face here.

Dr. **Eisenberg**. There is conflicting evidence about the degree to which educating doctors or educating beneficiaries will save money. But there are many who believe, based upon good data, that educating physicians and using the leadership of the medical community to provide them with the best data available about what is effective and what is not, can save a substantial amount of money.

Now I would be happy to help the Congressional Budget Office calculate the amount. What I am responding to is your request that we start tomorrow.

Mr. **Levin**. Let me just interrupt to ask if you are sufficiently optimistic about that that you would think it wise for us to provide this system. That we would have an increase in fees as we now expect, and that after four months we would take a look at volume, if we can do this. And to the extent that we do not begin to get volume under control, we would begin to reduce the amount paid for services.

Now, do you think—you are confident enough that by the steps you just suggested, we would begin to control unnecessary services that the remedy would not have to go into effect?

Dr. **Eisenberg**. No, the suggestion that I made is one that is available immediately, but I do not think it is a complete answer. I think it is only a partial answer. It may help some, but it must be instituted in the context of more than just education of physicians. We need reform of the way in which we pay physicians as well, and we need reform of the way in which we control the volume beyond than just educating physicians. But I think we can start today or tomorrow by educating physicians.

Mr. **Ginsburg**. I understand your frustration at the fact that for many years this committee has been confronted with having to reduce outlays for physician payments. And initially, it decided to freeze payments, while more far-reaching reforms were developed.

Some progress has been made, particularly in the direction of changing relative prices and moving toward a fee schedule. But certainly, policies have not been enacted that directly address the issue of volume.

I am not optimistic that there is something in the volume area that you could legislate tomorrow that by January 1, 1988 would begin saving money. If you really face that kind of pressure, it may be necessary to again look at the price side to get the short-term savings. Hopefully you also can put in place some of the more attractive but less immediate proposals to deal with the volume issue.

The Commission wants to help the committee with the volume issue. It just started taking it up a short time ago and does not have recommendations that are specific enough to write into legislation now. I think we will next year. We have another report to Congress due on March 1 and, given all the time that has been scheduled on the Commission's agenda and staff work on this issue, I think the Commission will be much more knowledgeable and much better positioned to come with recommendations at that time.

Mr. **Levin**. Thank you.

Mr. **Stark**. Mr. Duncan.

Mr. **Duncan**. Thank you, Mr. Chairman. HCFA has indicated that it believes that considerable growth in part B services from last year to this year is abnormal, and that future program costs will reflect historical levels of increase. Do you agree with HCFA on that assessment, or do you expect expenditures to continue to increase at this same rate in the future?

Dr. **Eisenberg**. The Commission has not had an opportunity to investigate the degree to which last year's increase could be an aberrant increase and reflect a one-time phenomenon, and the degree to which it may reflect the beginning of a different slope of that curve. So I am afraid that I, as a Commission member, cannot answer your question. Perhaps the staff has information.

Mr. **Ginsburg**. I do not think anyone at today's hearing has proposed that they understand why the volume of service has increased more rapidly in this recent period than it has in the long-term trends. Until we understand that, it is very difficult to make a projection as to whether it will continue or return to normal.

Actuaries do not have the luxury of saying they do not know. They are forced to put a number down. It is the HCFA actuaries' best judgment that this was an aberration, but certainly we cannot be confident that they are right.

Mr. Duncan. Thank you very much, and thank you, Mr. Chairman.

Mr. Stark. I want to thank both of you. But before I excuse you, I would like to, in the nature of constructive criticism, suggest to both of you that I think that this subcommittee and the full committee fully intend, either because of pressures from constituents or budget constraints, to implement some strenuous and strict controls within the next 2 years.

I am a little bit disturbed by discussions of education. We spend $12 to $16 billion a year educating physicians. If they cannot learn with that kind of money available then maybe education isn't the answer.

I have a hunch that every physician worth his or her salt in this country would have no quarrel with the fact of this study that Dr. Roper alluded to reports that 14 percent of the heart surgery performed is unnecessary and 30 percent of it is of marginal value, and approximately 45 percent having unnecessarily high costs.

If you want to research that another couple of years, fine. But I think the time is going to come when the physician is going to have to look to his brother or sister and say, hey, enough is enough. The physicians are not doing much about policing themselves in this area. As an arm of the Congress, I hope that you hear that we are becoming increasingly frustrated, and requested studies are a long time coming and of little value.

We have to do something. And while I have never liked the approach that the administration has taken for instance, in hospital payment, to cut the payments to hospitals across the board, they worked. Those approaches may not be the smartest things to do, and it may not be, Dr. Eisenberg, what you and I learned in business school, but in the absence of anything else, they may be the answer.

I am just saying that Congress is going to be pushed to do something drastic. You are not going to save the medical care delivery system much pain if you study it. If you can direct us in being a little more efficient in the way we cut programs, that is the help we need.

I say that in the best spirit I can, because the anecdotal evidence that we as laymen get would lead us to believe that there are a lot of wealthy physicians. Some ophthalmologists are getting $160,000 a year from Medicare. My constituents think that they might be able to get along on $120,000 from Medicare, and nobody's cataract surgery is going to suffer.

If you live in Canada you can get the same procedure there for a third of what you pay in this country, and I think you would have a tough time proving that Canada has lower quality medical care.

Now that is the push that is going to come to the shove here. I think that we can study and we can ponder, but sooner or later the public is going to ask Congress to act. I hope we can move along a little more in that direction.

Dr. Eisenberg. Thank you. I spend part of my time as a medical educator. And even as an educator, I am skeptical about the effectiveness of education, isolated from any other environmental change, to change physicians or any other human. I believe that education is a start. We can start with it now, but it will not work in isolation.

I agree with you, and on behalf of the commission, I promise you that we will work hard during the coming months to come back to you with more concrete suggestions. Hopefully we will be able to address this issue with you.

Mr. **Stark**. Great.

Mr. **Ginsburg**. Mr. Chairman, if I could add one thing.

Mr. **Stark**. Please.

Mr. **Ginsburg**. In the short life of this Commission, I do not think many have seen it as a study commission. I think we surprised many people when we were able to come to this committee and the Committee on Energy and Commerce 8 months after we were organized with specific recommendations as to how you could cut the budgets.

Mr. **Stark**. Pleasantly surprised, I might add. I mean, it was a good job, and it was appreciated by the members of this committee.

Mr. **Ginsburg**. I expect that we will continue to operate in that way and come to you, in not too long a period of time, with additional specific recommendations.

Mr. **Stark**. Mr. Frenzel?

Mr. **Frenzel**. No questions.

Mr. **Stark**. Thank you, gentlemen, both very much.

Our next witness is Dr. James Todd, the deputy executive vice president of the American Medical Association, who is accompanied by Mr. Bruce Blehart, the director of the department of Federal legislation for the American Medical Association.

Welcome to the committee, gentlemen. Your prepared testimony will be entered in the record in its entirety, and please feel free to expand on it, summarize it, and add to it, or explain it to us in any manner that you are comfortable. Dr. Todd.

STATEMENT OF JAMES S. TODD, M.D., SENIOR DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION

Dr. **Todd**. Thank you, Mr. Chairman. We appreciate this opportunity to be with you to discuss the 1988 Medicare part B premium increase. I will make a brief statement that amplifies and explains our written statement.

The AMA is as much dismayed as anyone else by the projected need to increase the part B premium by 38.5 percent. While the issue of major concern is this 38.5 percent increase, we should remember that the formula for determining premium increases is set by statute. And as you have already been informed, nearly one-half of that amount reflects the administration's need to build up trust fund reserves that were depleted by its previous decision to spend down the reserve.

We agree that this large increase and its potential effects on beneficiaries deserves some very close consideration. However, the real issue that needs to be addressed is the total of the expenditures for physician and other part B services under Medicare and not the half of the amount that is purely catchup.

We have been told by Medicare that the projected level of spending for part B services for the period of July 1, 1986 through June 30, 1987 represents a 19.9 percent increase over the previous 12-month period, and that this increase would have been 18.8 percent, absent the required standard on faster claims processing.

Mr. Chairman, this level of increase should not have been unexpected or seen as unrealistic. An 18.8 increase in part B expenditures is not inconsistent with the historic growth pattern of the part B program. On average, the program has grown by 17.2 percent annually over the past ten years, and has experienced an annual growth of over 18 percent in 10 of the past 14 years.

Nonetheless, we believe it is appropriate to dissect this approximately 20 percent increase and make efforts to isolate and correct any elements that have inappropriately caused program expenditures. According to HCFA, "when the increases accounted for by enrollment and growth and reasonable charges are factored out, a residual increase of approximately 9.05 percent remains due to increased utilization and intensity." It is this figure that we believe requires explanation, for the inference has been made that this amount is simply too much for the program to bear.

Most of this increase, we believe, is attributable directly to Medicare beneficiaries receiving necessary and valuable services for their well-being. Furthermore, this level of expenditures can be traced to a myriad of factors, including the growth and aging of the Medicare population, the deductible being maintained at the level set in 1981, assignment being more readily accepted, charges and coinsurance having been held down, and costs declining in relation to price.

It is also our experience that utilization and intensity under part B is increasing for the Medicare population. As acknowledged by HCFA, this element has averaged a 6.2 percent increase over the past 10 years, and a 6.7 percent increase over the last 5 years. The additional current 2.35 percent should be evaluated in the light of increased benefits that have been mandated under part B, and on pressures on physicians to provide a greater share of the care that Medicare beneficiaries receive outside of the hospital. In addition, more beneficiaries are availing themselves of part B services. The proportion of beneficiaries receiving reimbursed physician services increased from 67 to 76 percent between 1981 and 1986. Shorter hospital lengths of stay and increased use of nonhospital sites for care have resulted in a more intensive physician service being provided. It is reasonable that part B expenditures will reflect an accelerating increase based on utilization and intensity.

Now we have seen no evidence to indicate that the increase in utilization or intensity was inappropriately caused by physicians. In our full statement we have also discussed a draft report which you have heard about today, prepared for the Department of Health and Human Services, that finds increases in intensity do not reflect fraudulent or improper changes in billing practices. If such were the case, I can assure you, we at the AMA would be at the forefront of trying to address such a problem.

We believe the increase in the use of physician services represents expanded access to care that the Medicare program holds out to the elderly, that public policies have reinforced, and that beneficiaries have come to expect. The increase in program expenditures illustrates that improvements in access are not without cost.

In conclusion, we believe physicians have received unjustified adverse publicity over these projected increases in the part B premium. Physicians have participated in a voluntary fee freeze, have been subjected to congressionally imposed reimbursement and fee freezes, and now are exposed to the MAAC price controls. No other sector of our economy and no other government programs have had so many price controls.

We believe this committee is to be commended for this hearing aimed at identifying the facts and setting the record straight, because misinformation has a doubly unfortunate aspect of breeding mistrust between patients and their physicians.

The AMA wants to work with you and your committee in seeing that Medicare beneficiaries continue to receive needed quality health and medical care services and that public dollars indeed are spent wisely.

We will be happy to answer any questions you might have.

[The statement of Dr. Todd follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Ways and Means
U.S. House of Representatives

Presented by

James S. Todd, M.D.

RE: Medicare Part B Premium for 1988

September 30, 1987

Mr. Chairman and Members of the Committee:

My name is James S. Todd, M.D., and I am Senior Deputy Executive Vice President of the American Medical Association. With me is Bruce Blehart of the Association's Department of Federal Legislation.

The AMA appreciates this opportunity to appear before the Committee to discuss the announced Medicare Part B premium increase for 1988. We are disappointed in the the projected need to increase the Part B premium by 38.5%, and we hope information--not heretofore available--will be forthcoming at this hearing so that causes for the increase can be identified and analyzed. The AMA agrees that this large increase and its potential effects on beneficiaries deserve close consideration. The real issue is the level of total expenditures for physician and other Part B services under Medicare.

Mr. Chairman, physicians have taken part in a voluntary fee freeze, been subjected to Congressionally-imposed reimbursement and fee freezes, and then subjected to the currently imposed price controls known as MAACs. No other sector of the economy and no other government program has so many price controls.

It is also important to point out that a substantial percentage of the projected premium increase is directly attributable to lack of an increase in the premium in 1986 and the fact that the Administration last year decided not to impose the full 1987 premium increase. In 1987, the premium was increased to $17.90 instead of $19.30. The extra $2.90 was funded by spending down trust fund assets. If the full 1987 premium increase had been imposed, that premium would have been $19.30 (a 21% increase) and the potential 1988 premium of $24.80 would represent a 28% increase.

It is the experience of physicians across the country that shorter hospital stays and increased use of non-hospital sites for care frequently have resulted in a more intensive physician service being provided. By way of example, a hospitalized patient who (previous to the PPS) may have been in the hospital for a seven-day period and who today is discharged on the fourth day following surgery will utilize more Part B covered ancillary services and require more intensive physician involvement. While the hospital and personnel who routinely would have provided patient care in the hospital (Part A) will be relieved of responsibility on discharge, the fact that patient care is still needed does not disappear.

With physicians strongly discouraged from admitting patients, and especially with the increasing age of the Medicare population and the rapid growth of ambulatory surgery, it is reasonable that Part B expenditures will reflect an increase in utilization/intensity. We need to examine carefully the extent to which savings accruing to the Part A side of Medicare may offset expenses added to the Part B side.

When the freeze on physician reimbursement was incorporated into the Deficit Reduction Act of 1984, the Congress called for a study to analyze whether physician "gaming" would take place. Preliminary results of a similar study being completed by Peter D. McMenamin, Ph.D., for the HHS Assistant Secretary for Planning and Evaluation, point out that physicians have been scrupulous in their dealings with the Medicare program. The draft report indicates that the increase in intensity does not reflect fraudulent or improper changes in billing practices. Dr. McMenamin also examined the issue of visit "unbundling" and concludes that there was no volume response with respect to follow-up visits.

To date, we have seen no evidence to indicate that the increase in utilization/intensity was inappropriately "caused" by physicians. If there were, the AMA would be at the forefront of efforts to address such a problem.

To the contrary, Dr. McMenamin's analysis points out a number of plausible factors, including:

- o The growth and aging of the Medicare population;
- o Maintaining the deductible at the level set in 1981;
- o Assignment being more readily accepted;
- o Charges having been held down; and
- o Costs of office visits declining in relative price.

Dr. McMenamin aptly points out that any volume increase would not be inconsistent with a demand response on the part of beneficiaries.

An additional factor not mentioned in this study that directly relates to the relative price of physician services is that approximately 70% of the Medicare population are covered by private medigap policies that effectively provide first dollar coverage on deductible and coinsurance. Increased utilization by beneficiaries as a result of lower real out-of-pocket costs is not to be unexpected. The recently completed Rand Health Insurance Experiment has found that a reduction in beneficiary cost-sharing for services leads to an increase in the volume of services used.

Mr. Chairman, the increase in the use of physician services represents expanded access to care that the Medicare program holds out to the elderly, that public policies have reinforced, that the beneficiaries have come to expect, and that physicians continue to provide. In fact, physicians have provided this expanded level of care with virtually no increase in program reimbursement between 1983 and 1986. The increase in program expenditures illustrates that improvements in beneficiary access are not without cost.

Medicare Part B Expenditures

We have been told by Medicare that the projected level of spending for Part B services for the period of July 1, 1986 to June 30, 1987 represents a 19.9% increase in expenditures over the previous 12-month period, and that this increase would have been 18.8% absent the required standard on faster claims processing. This level of expenditure increase should not be unexpected or seen as unrealistic. An 18.8% increase in Part B expenditures is not inconsistent with the historic pattern of Part B program growth. On average, the program has grown by 17.2% annually over the past ten years and has experienced an annual growth of over 18% in ten of the past fourteen years.

Without question, the growth in the Part B program over the years represents increased access to effective and sophisticated health care services for our nation's elderly and disabled.

Analysis of Part B Expenditures

It is appropriate to dissect the approximately 20% increase in Part B expenditures and make efforts to isolate and correct any elements that have inappropriately caused program expenditures. The Health Care Financing Administration (HCFA) has issued the following facts:

> "During the twelve-month period, July 86–June 87, carriers paid a total of $22.1 billion in benefits, an increase of 19.9% over the same twelve-month period in the prior year....
>
> Data for the most recent six-month period indicate that the rate of increase in payments appears to be accelerating, with benefits increasing by 22.4%.... However, both the twelve-month and six-month rate of increase probably overstate the underlying trend since claims processing has accelerated. A rough estimate of the real increase, net of the effect of faster claims processing(,) is 18.8% for the July 86–June 87 increase and 16.6% for the most recent six-month period. [NOTE: FOR THE TWELVE-MONTH PERIOD, 5.5% OF THE INCREASE IS DUE TO CLAIMS PROCESSING ACCELERATION, AND DURING THE PAST SIX-MONTH PERIOD VIRTUALLY 26% OF THE INCREASE IS DUE TO THIS FACTOR.]
>
> Taking the adjusted 18.8% increase experience during the most recent twelve-month period, the contribution of price, beneficiary population and utilization, (are) as follows:
>
> o reasonable charges increased to 6.8%.
>
> o enrollment increased 2%.
>
> When the increases accounted for by enrollment and growth and reasonable charges are factored out, a residual increase of approximately 9.05% (emphasis added) remains due to utilization/intensity and this 9.05% increase is considerably higher than what we have experienced in recent periods. Utilization/intensity has averaged 6.2% per year for the last ten years, (and) 6.7% for the last five years.

Prior to focusing on the element labeled as "utilization/intensity," I feel it important to point out that the 6.8% attributable to "charge increases" came about due to justifiable Congressional action that allowed increases in prevailing charge levels for the first time since July 1, 1983. Most of this level of increase was given to physicians who entered into agreements with the government to accept all of their Medicare claims on an assigned basis. Non-participating physicians saw their first increase in Medicare payments on January 1, 1987. Mr. Chairman, I cannot believe that the limited amount of increase allowed for prevailing charge payments can be at issue based on the fact that Medicare has historically under-reimbursed for the services provided.

Utilization/Intensity

The residual from the specific factors mentioned above arbitrarily has been labeled as "utilization/intensity," with the inference being that this amount is simply too much. Mr. Chairman, most of this increase is attributable directly to Medicare beneficiaries receiving necessary and valuable services for their well being. Furthermore, this level of expenditures can be traced to a myriad of factors. We have requested the Health Care Financing Administration to break out specifically what has been purchased with the Part B dollars. To date we have received no formal response to the specific questions raised in our inquiry. (A copy of our letter to HCFA is attached.)

First of all, an expenditure increase is by no means wholly inappropriate. It is our experience that utilization/intensity under Part B is increasing for the Medicare population. As stated by HCFA, this element has averaged a 6.2% increase over the past ten years and a 6.7% increase over the last five years. An increase of 2.35% on top of the 6.7% needs to be evaluated in light of increased benefits under Part B and on pressures on physicians to provide a greater share of the care that Medicare beneficiaries receive. In addition, the fact that more beneficiaries are availing themselves of Part B services must be considered. The Medicare actuaries, for example, estimate nationally that the proportion of beneficiaries receiving reimbursed physician services increased from 67% to 76% between 1981 and 1986. This fact alone accounts for a significant increase in Part B expenditures.

Conclusion

In conclusion, physicians have received unjustified bad publicity over the projected increase in the Part B premium. This Committee is to be commended for this hearing aimed at identifying facts for the public. Unfortunately, the same public that has been told that physicians are the root cause of the problem is unlikely ever to be presented with a clear statement of the facts as to what has caused the growing expenses of Part B of Medicare. Such misinformation has the doubly unfortunate aspect of breeding mistrust between patients and their physicians.

Mr. Chairman, the AMA will be pleased to work with you and the Committee in seeing that Medicare beneficiaries continue to receive quality health and medical care services and that public dollars are spent wisely. Whether public expenditures are for the purchase of defense equipment, food or housing under welfare programs, or medical services under Medicare, the public has the right to expect accountability. Such accountability necessitates the availability of all of the facts, and we will also work with the Administration when that information, as we requested, is available from HCFA.

We will be pleased to respond to any questions from the Committee.

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JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

September 18, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201

Dear Dr. Roper:

First, let me again express my appreciation for the opportunity to meet with you to discuss the increase in Part B expenditures. The on-going dialogue between our organizations is essential in adequately addressing the underlying causes necessitating the proposed premium increase and responding to the high level of Congressional and media interest in this issue. Unfortunately, some critics, in a rush to judgment, have unfairly laid the blame on physicians for the increase in total Part B expenditures without any documentation of the root causes. Congress and the Administration must determine the underlying factors which explain the increase in Part B spending before even beginning to entertain legislative or regulatory options.

As you know, the Health Subcommittee of the House Ways and Means Committee chaired by Representative Stark will be holding a hearing on September 30 to look into this matter. The AMA has been invited by Chairman Stark to testify at this hearing and we intend to participate. In order for us to develop our testimony, it will be helpful for us to obtain information that is available only from the Health Care Financing Administration.

This letter is to request your immediate assistance in obtaining answers to the following questions so that we will be able to address these important issues:

1. It has been reported that Glen Hackbarth indicated that one reason for the 38% increase in premiums related to a decision by the administration to "spend down some of the contingency reserve." (New York Times, September 15, 1987) What portion of the 38% increase in the proposed premium can be attributed to the catch-up necessary because of the trust fund spend-down? How was it that the premium could be held down in light of the statutory requirement for the Part B premium to cover 25% of program costs?

2. What portion of any increase can be attributed to shifts in services from Part A to Part B? Specifically, can any of the increase be attributed to services that are now provided on an outpatient basis that would previously have been provided under Part A, such as services attributable to increased use of improved outpatient technology, incentives for outpatient surgery, reduced lengths of stays due to DRG implementation, and utilization controls such as preadmission reviews that have shifted procedures to the outpatient setting? Can any of the increase be attributed to outpatient work-ups prior to hospitalization? Ancillary service costs? Technical components?

3. What percentage of the increases can be attributed to general inflation? Increased patient population? Increased number of eligibles filing claims? Increased intensity due to shorter hospital lengths of stay? Increased intensity due to the growth of the over age 75 population.

4. Could you identify the increases by practitioner classification and other service components? For example, how much of the increase is attributed to "physicians" under Section 1861 (r)(1) (M.D. and D.O.) and each of the other practitioners identified in 1861 (r) (podiatrists, chiropractors, optometrists, and dentists)? What portion of the increase is attributable to non-physicians services such as durable medical equipment and other part B services (including home health services provided by a home health agency, rural health clinic services, etc.)?

5. Press reports have also indicated that a significant portion of the increase can be attributed to "increases in fees." Previous to the period in question, Medicare reimbursement was strictly controlled through freezes on prevailing and customary charges and limits on updates in the MEI. Also, fees of non-participating physicians were frozen at the April - June, 1984 levels. Physician reimbursement and fees are still rigorously controlled. Is it your view that the larger-than-expected increases are caused by physician fee increases? If so, we would be interested in knowing to what extent and the specific fee increases that have caused the reported increase?

6. Is there any impact caused by the prompt payment provisions? If so, what percentage relates to increased costs due to prompt payment and what percentage relates to interest paid on overdue claims?

7. Are administrative costs factored into this increase? If so, what percentage of the increase can be attributed to carrier costs, including increased carrier responsibilities, the participating physician program, providing directories of participating physicians, processing of MAAC information and surveillance and monitoring of the MAAC program?

8. The press has indicated that part of the increase relates to increased utilization of services by Part B beneficiaries. Is the Department aware of specific instances of inappropriate utilization patterns or upcoding under Part B?

9. In that controls on physician fees have held down the costs of these services to levels lower than they would have been without the fee controls, how much increased utilization can be attributed to increased demand induced by lower real costs?

10. At the time of implementation, it was projected that implementation of the HMO/CMP option could actually cost the program more money. Can any of this increase be attributed to increased use of the Medicare HMO/CMP option?

11. What percentage of the increase can be attributed to charges submitted by participating physicians? Non-participating physicians?

12. What percentage of the increase can be attributed to increased reimbursement levels to participating physicians?

13. Can any of the increase be attributed to the availability of new or expanded benefits such as the expanded coverage for vision care?

14. Can any of the increase be attributed to payments made during the period in question that were, for whatever reason, deferred from an earlier period?

15. What portion of the increase can be attributable to services provided in hospital outpatient departments? Ambulatory surgical centers?

I recognize that these are complex questions requiring detailed answers. Such information will enable us to address more fully the issues surrounding the announced increases.

I look forward to your prompt reply to this request. In light of the short time available to us, please feel free to have your staff contact our Washington office with the information as soon as any of the information is available.

Sincerely,

James H. Sammons M.D.

James H. Sammons, M.D.

JHS/dl

Mr. **Stark**. Mr. Levin?

Mr. **Levin**. I am not quite sure how to react. We are looking for solutions, and in a sense you say there is no problem.

Dr. **Todd**. No, I do not believe I said that at all, sir. There is a problem, but the cause of the problem—as you have heard today—is not really physician reimbursement or physicians being fraudulent, but volume. We clearly recognize that volume is a problem. We share your frustrations as to how to get at this and how to get at it in an appropriate fashion.

You have heard adequate testimony today beginning with Dr. Roper, that some procedures may be deemed in retrospect, to be unnecessary. Part of the problem is that it is much easier to make those decisions in retrospect. Also, the art and science of medicine is very imprecise, and many times it takes a significant length of time and accumulation of data in order to be able to say unequivocally that certain procedures in certain cases are unnecessary.

We also have the problem with defining what is unnecessary. Does unnecessary mean totally without benefit, or does it relate to medical necessity? For example, if somebody has a mole on some part of their body that they want to have removed, there may be no medical necessity for the removal. They are not going to be harmed by that mole remaining. But they may indeed be benefited, for a whole variety of reasons, by having that lesion removed.

And as you can see we have some concern about the definition of unnecessary services.

Mr. **Levin**. But it is not finger-pointing. I do not think the chairman nor I, nor anybody else here is trying to finger-point. We are trying to analyze.

I gleaned from the testimony this morning and this afternoon something very different than that the issue of unnecessary services is de minimis. I mean, that is not what Dr. Roper said. He said it is not all the problem, but it is a substantial portion. They do not know quite how much. And the fact that this growth in volume, that fact that it has been consistent over the years indicates we have to tackle it and not run away from it.

You just heard Dr. Eisenberg. I do not glean from his testimony at all, the feeling that there is no abuse in the system. See, but you come here and essentially say there is no abuse. That is what you say. I mean, that is what I hear. And if there were any, the first people who would be getting at it would be physicians.

Dr. **Todd**. I am not sure, sir, that I said there was no abuse. I think Dr. Roper said this morning that there was some unnecessary services, and I would not dispute that. What we need to know and what Dr. Eisenberg has testified that we do not know, is how to develop a mechanism by which to determine what are unnecessary services and what are fraudulent services, if indeed there are some of those out there. But what we are trying——

Mr. **Levin**. There is a difference between unnecessary and fraudulent. The gist of their testimony is that there is enough unnecessary services, that the expansion has been so substantial beyond what would be deemed necessary, that the commission is making a major effort to study it. And HCFA believes that major steps have to be undertaken to get at it. They say it is difficult.

But the gist of your testimony, and I do not contend for a moment that this is the only problem, is not finger pointing. It is one of the elements, but you seem to be saying if it were a significant problem physicians would have been working to weed it out.

You are shaking your head yes.

That is not what Dr. Roper is saying. That is what Dr. Eisenberg said. And I do not think that it is credible.

Dr. TODD. I do not see any need that I need to agree necessarily or totally with Dr. Roper or Dr. Eisenberg, although let me hasten to add that we do support the work of the Commission in looking at these areas. We have had close communication and cooperation with the commission and we share their concerns that some sort of a quick fix is going to make it very difficult to proceed with a long term solution to the problem.

But I do not think it is really appropriate to say that physicians are not involved in exposing unnecessary activities. After all, who did the studies that came out of the Rand report having to do with the perhaps unnecessary numbers of carotid artery surgeries that were being done? Those were physicians.

Physicians are constantly evaluating and reevaluating what it is they do.

Mr. LEVIN. I am not saying physicians have not done that, but you are saying that if there were abuse, you would be in the vanguard of getting at it and that is, ergo this is not a significant problem, unnecessary services.

Dr. TODD. I think the extent of unnecesary services remains to be documented and I think you have heard testimony say that this morning. What actually is the level of unnecessary services remains to be defined in a consistent fashion.

Mr. LEVIN. Do you think it is significant or not? Do you think the level of unnecessary services is likely a significant problem?

Dr. TODD. I do not think we have any good data to allow us to answer that question one way or the other, at this point. I really do not.

Mr. LEVIN. That is not what Dr. Roper says or Dr. Eisenberg. So when you invoke them——

Dr. TODD. I do not invoke them to defend my position. I remember Dr. Roper saying that unnecessary procedures have some contribution and I think he said that they were not aware of what that total contribution was either. While I do not think any of us are able to isolate that contribution, there are a great deal of activities going on within the medical profession today to limit unnecessary services for example, you have seen the College of American Physicians with their guidelines for testing.

We are going to see increasing activities of specialty societies and organized medicine in general, to study and try to understand what procedures are of value, and what procedures could be eliminated without harm to the patients. But I really do not believe, at this point, that we have adequate documentation to say that there is 10 percent, 20 percent, or 30 percent unnecessary procedures being done.

Mr. LEVIN. When do you think you will be ready with your recommendations in a very concrete fashion?

Dr. TODD. I do not have really any clearer crystal ball than anyone else who has testified today. I can tell you we are working hard on it. We are concerned about it.

At the AMA we have developed an entire department to look at it, to try and get the data, to see what HCFA has, to work with the Physician Payment Review Commission. We do not want to have beneficiaries or patients in general receiving services that are of no value to them.

Part of the problem is definition. For example, and we see this happening not infrequently, a physician in an emergency department in the middle of the night is confronted with an individual who has chest pains. The diagnosis could be any number of things. The physician says I really believe I cannot make a determination tonight, I want to observe this individual overnight. By the next morning, the pain is gone and the electrocardiogram is normal. In retrospect, somebody reviewing that chart could very easily reach the conclusion that there was an unnecessary service because there did not turn out to be any treatment or any specific diagnosis put with it.

It is this variability and the uncertainty of patients and their conditions that make it very difficult, except in retrospect, to decide what is an unnecessary service.

Mr. LEVIN. I wish you well and I do not want you to think, I do not think there is hostility. I think there is skepticism. Because you come here and you minimize, you accentuate the difficulties and what that sounds like to Congress is, "do not bark up that tree, it is the wrong one."

Yet, you say we do not know enough. You come here with implications that I find very conclusionary at the same time you say we do not have very much information. With this kind of a pattern of growth in volume and with statements—the people who are working at this, HCFA, think there is a real problem there. The commission believes there is a real problem in terms of unnecessary services.

You do not come here and say we think we have got a real problem here of unnecessary services, we are going to work with you to get at it. You come here and say we think it is more likely imaginary than it is real. That is how I hear you and I think that is a mistake.

Dr. TODD. If that is the message that you have received from what I have said, then I have said it very badly because that is not the intent of our statement.

Our intent, first of all, was to say that we do not believe that the problem of increased expenditures on part B is related to physicians fees. I think the record is quite clear on that and I probably went overboard in order to convince you of that because they have been controlled by congressional mandate now for more months than we would like to admit.

The problem is not the physicians fees, the problem is the total expenditures going out for Medicare part B. We freely admit there is a problem in volume.

I say volume, you say unnecessary services. We are probably both right.

Mr. **Levin**. It is likely a significant element. At least that is what HCFA tells us and that is the assumption of the commission. How much they are not sure, but significant for us to really try hard to get at.

Dr. **Todd**. We are willing to get at that. Again, I may have said it poorly, as we agree with you about a problem in the volume of services being provided. However, what we need to do is to find a way that is reliable and creditable to separate out what is the needed increase in volume because of the increased severity of illness of beneficiaries and our increased ability to provide care and what is perhaps unnecessary or nonbeneficial care. I think you would agree that you have to separate those two areas out before you can reach any reasonable conclusion as to whether or not the increases are legitimate.

For example, 10 or 15 years ago when an elderly patient came in with certain conditions and if they were over such and such an age, you may say look the risk is so great, we are not going to do this procedure. It just does not make any sense to do it. Today, the health of the elderly, on balance, is better. I can think of procedures that I would do today without hesitation because of better technology, better health of the individual, and better ancillary support, that I would not have done 10 or 15 years ago.

Mr. **Blehart**. Also, Congressman, on whether or not there are services provided that may be inappropriate, there is no question that some services are provided that fit within that category and that definition. However, it is a very difficult determination to be able to make up front and be able to say right away you know that this is something that should not be done.

For certain services, it is not that difficult to determine the appropriateness, such as chelation therapy, that is unrelated to lead poisoning. That is the sort of activity that the AMA is in the forefront of identifying, through its DATTA project, as well as JAMA and other publications, to determine and point out what is indeed an appropriate type of care to be provided.

The single study cited by Dr. Roper, was published in the Journal of the American Medical Association, showing the appropriateness of second opinions for coronary artery bypass surgeries. This is an example of how the AMA is involved in the education of physicians, to better enable them to provide appropriate services for their patients.

Furthermore, the AMA has even gone on record, in making a statement to the Physician Payment Review Commission, that the association will be willing to help in identifying those physicians who are providing inappropriate services by supporting the identification of those physicians and the possible sanctioning of those physicians. So the AMA is by no means putting its head in the sand and saying that this is no problem whatsoever.

Mr. **Levin**. It is just interesting how differently you view the study, and I will finish with this, and how differently you and Dr. Roper describe the same study. I just want you to know how it sounds.

You conclude from it, you use it as an argument. This study points out that physicians have been scrupulous in their dealings with the Medicare program. Dr. Roper urges that it is much too limited a study, geographically and in terms of its subject matter, to have that kind of a conclusion written out.

Dr. **Todd**. I do not think there is any question that reasonable people can disagree on the interpretation of data, and obviously do. And I do not disagree with Dr. Roper that the sampling might have been different. But, I think that as far as the study has gone, and bear in mind the study has not completed in terms of surgical procedures and the like, on balance Dr. McMenamin could not find any conclusive evidence of physicians gaming the system.

There are exceptions to every rule and we would like to find those exceptions and do something about it. But on average, Dr. McMenamin, the author of the study could find no consistent evidence of gaming the system. What he told Dr. Roper or what Dr. Roper and his people choose to conclude from Dr. McMenamin's presentation, legitimate differences may exist. I do not think we are trying to read something into the study that Dr. McMenamin would take offense at, as the prime investigator.

Mr. **Blehart**. Also, the study is not, frankly, limited only to the Dakotas. The study is a six-State study at this point that covers both of the Dakotas, the State of Washington, the State of Minnesota, the State of Indiana and the State of South Carolina. It should not be viewed as a strictly isolated issue by the fact that it only covers six States.

What is important to note is that this was the only study that we are even aware of that has looked at the specific issue of the so-called gaming by upcoding or scheduling additional visits. On those two points, the study found that physicians have been scrupulous.

Mr. **Levin**. I will finish, as Dr. Roper pointed out, there is more involved than recoding or extra visits. It is a question about the system, not about how straight or scrupulous doctors are.

In that sense, it is not a question of criminal activity. It is a question of a system on a cost plus basis, on a service basis and how you make it work.

Dr. **Todd**. I think you are absolutely right, sir, that this is a terribly complicated situation, one that all of us have a high level of frustration over and one that I think we would like to have all behind us. But the danger is that when we try and fix it so quickly, it never gets behind us.

Mr. **Levin**. Thank you, Mr. Chairman.

Mr. **Stark**. Mr. Frenzel.

Mr. **Frenzel**. Thank you, Mr. Chairman.

Dr. Todd, thank you for you testimony. I must say, as one auditor, it did not strike my ears as harshly as it struck those of my colleague from Michigan. We appreciate your willingness to work with the committee and with the department to try to root out whatever excesses there are in the system and all of us know that there are excesses in any system of this size or maybe any system that ever existed.

My question is a little different. That is, does the AMA have any estimates or analyses of what percentage of these costs are generated by liability insurance costs?

Dr. **Todd**. It is awfully hard to estimate a dollar figure.

Let us put it this way, the increase in part B costs, because of the congressionally controlled fees that physicians can charge, I do not believe that the fees themselves are the prime cause for the increase in the outlays or even reflect recent increases in malpractice costs.

We have figures to show overall that with malpractice premiums rising on the average of 25 to 40 percent across the country that somewhere between 5 and 10 percent of a physician's gross—depending on their specialty—may end up going to malpractice insurance premiums.

Mr. **Frenzel**. May I interrupt for a moment? You said an increase of 25 to 40 percent. Over what time frame are you talking about?

Dr. **Todd**. Yearly. We have seen at least 25 percent increases on average in professional liability premiums across the country for the last 3 years and the actuaries do not tell us to expect any reduction in this.

Mr. **Frenzel**. I understand that certain physicians in high risk litigious occupations may have difficulty retiring because they carry over residual costs which have to be paid before they can even peacefully move on to greener pastures. Is that true?

Dr. **Todd**. That is true. There also is another of the coin, Mr. Frenzel, in that there are physicians because of the pressures of professional liability who are beginning to restrict their practices and cease to do certain procedures. About 50 percent of the orthopedic surgeons we have polled have said that they have limited their practices to procedures that are less risky, for which they are less likely to be sued.

We all know the story of the obstetricians and gynecologists all across the country, where they are stopping delivering babies because of the risk involved. There is an immediate danger of areas of this country where patients are going to be unable to receive certain types of care because physicians there do not believe they can sustain the pressures of the liability situation.

And you are quite right about the situation at the end of the professional life of a physician involved in a claims made insurance policy. There is the so called tail coverage that may amount to many hundreds of thousands of dollars as a single lump sum in order to make sure that they or their estate are protected after they cease to practice medicine.

Mr. **Frenzel**. Of course, this particular facet of medical cost is not within the jurisdiction of this committee. This committee can, of course, be outraged over things within its jurisdiction. But I think that when we worry about medical costs we ought to worry across the broad spectrum of medical costs instead of blaming the same party every time.

But I think we have a lot of things we need to do besides only those which fall under the immediate jurisdiction of this committee and I hope that Congress will one day learn to expand its horizon and to be able to spread its outrage broadly. I have heard the terms shocked and astounded used all day.

When costs generally are moving in an upward direction, I am surprised a bit that we all should be shocked at this premium that we have to assess is going up. It seems to me to be no great surprise.

You can comment on that or not.

Dr. **Todd**. Congressman, I think you hit an extremely important point when you begin to talk about volume increases. There is a contribution caused by professional liability to volume increase, based on defensive medicine. However, I really do not like the term because we really ought to be talking about objective validation of clinical judgment. This is exemplified best by the individual brought to the emergency room who has had a minor head injury. In this day and age it is not safe legally for a physician not to order a series of x rays of the head. It may not tell him a thing, but for legal liability purposes most department physicians will not let a head injury out of the emergency department without x rays being done.

Mr. **Frenzel**. And I do not blame them. Your previous example of the man with chest pains. Send him home and something happens, you get sued for sending him home. I think the problem is a little deeper than simply that investigated by the department by that fine gentleman whose name none of us can pronounce.

Again, I thank you for your testimony.

Mr. **Stark**. Mr. Pickle.

Mr. **Pickle**. Mr. Chairman, I have not had a chance to hear all of the testimony. I have been looking through some of it.

As I see it, Dr. Todd, you are saying that a substantial percentage of the premium increase is directly attributable to the lack of an increase in the premium in previous years.

I made a point earlier this morning that one reason we have this difficulty is that we withheld a premium increase, kept it low using our reserves on a spend down basis. Then all at once we realize that reserve has run out and we have to make up a big chunk of revenue.

That is one reason the increase looks so large. We have been using the reserve and now that it is expired, we are faced with the cold reality. That is neither saying it is good or bad or right or wrong but we have done it, and that is one reason. I assume that you say this policy has been one cause.

I also assume that you said that one reason for this sharp increase is that we have encouraged shorter hospital stays and we have encouraged an increased use of nonhospital sites for care and that naturally resulted in more intensive physician service.

I do not know that we have got any concrete evidence, I asked Dr. Roper this morning to indicate that the increase in utilization has actually caused the problem. I did not get from Dr. Roper this morning a complete breakdown of the outlays showing in what categories this increase has been brought about.

He did give me some percentages, but it was the first time I had seen them. I am just wondering if you have any breakdown to pinpoint? And if you have, I think we have got to consider it and see what can be done about it. Those are some of the questions that I think legitimately should be raised.

It is not going to be a question of whether you are going to have to raise the premiums, that is a fact. But I guess in all fairness, we have to try to find out what is causing the higher outlays. Do you have any further comment on that?

Dr. **Todd**. No, Mr. Pickle, I think you have essentially the same figures that we have. Dr. Roper and HCFA have admitted that almost 50 percent of the premium increase is catch up. Of the expenditure increases 2 percent of it is the growth in the elderly population and 6 or 7 percent is increases in physician reimbursement which were allowed by Congress over the past several years.

This ends up with about 9 percent of the 20 percent that is left, and no one can really explain very clearly as to what it constitutes. We have written to Dr. Roper, and you have a copy of our letter attached to our written testimony, asking for information that would help us reach conclusions as to what this 9 percent really represents.

How much of it is severity of illness? Are the elderly more sick? Are they requiring more intensive services? What is the level of marginal services that we might be able to bring out of that? Dr. Roper said this morning that the volume of claims that come in are overwhelming. It takes a significant length of time to analyze this data and reach that conclusion. We have hopes that eventually that information will be forthcoming.

In all honesty, we do not know, nor has anybody been able to tell us, even from what I have heard this morning before the committee, what is the composition of the 9 percent increase that cannot be easily explained by increases in population, increases in physician payment, or even catch up because of the spend down activity on the trust fund.

Mr. Pickle. I appreciate your comments. It seems to me like you, as a group, are almost in a catch-22 question. We passed the DRGs and we say get your patients out of the hospital. We have gotten them out of the hospital and that part A program has shown a very sharp, progressive improvement and we should all be proud of it.

But as we have gotten patients out of the hospital, we have also moved them out at a time when they need services. So if some services are over used, that is over utilized, it is only natural because we must try to find some way to keep these patients from going back in the hospital. If you say you ought not to have any increased outpatient care, then I will tell you, they will go back to the hospital pretty quickly.

I do not know that I would refute the fact that physicians are receiving more pay and the volume of services has increased. If you look at percentages on first blush it looks like maybe physicians were the cause of it.

I think there are other reasons to be put into the equation that we ought to evaluate as we try to find an answer for this increase. But Doctor, we have got to increase the premiums. It has got to be done, so we might as well brace for that.

Dr. Todd. We share your concerns. We share your frustrations. We share your concern about the lack of data that allows us to dissect this issue. We want to be a part of doing the analysis because we understand, I hope as well as this committee does, that we cannot continue to increase the expenditures at the rate at which they are going.

We need to find out what it is that we can do legitimately to control that rate of increase and make sure that the American public is getting value for the money spent on health care.

Mr. Pickle. I thank you, Doctor. Thank you, Mr. Chairman.

Mr. **Stark**. Mr. Pease.

Mr. **Pease**. No questions.

Mr. **Stark**. Mr. Duncan.

Mr. **Duncan**. Thank you, Mr. Chairman.

I apologize for having to step out for a few minutes. I had a serious conflict.

Can you suggest anything that physicians can contribute to deficit reduction to bring the program's growth in line with the rest of the budget? Do you have any suggestions?

Dr. **Todd**. I wish I could, Mr. Duncan. I think that physicians, to the best of their ability, have contributed by first a voluntary fee freeze and then clearly their fees and Medicare payments have been frozen over the subsequent years. The average payment out of Medicare now only represents about 78 percent of what the physician would charge a non-Medicare patient or might receive from a non-Medicare patient.

The assignment rate of claims coming into HCFA far exceeds the number of physicians who have signed up as participating physicians and it becomes clear that physicians all across the country are trying to take into account the economic circumstances of their patients. It is a little bit bothersome when a physician will waive a copayment and a deductible and then be investigated for fraudulent activities because if he waives those fees then it was not his true fee. There is some frustration on that regard.

Physicians have analyzed themselves, and Dr. Eisenberg emphasized this. We have had programs across the country known as economic grand rounds where physicians in hospitals have reviewed cases as to the appropriateness of the procedures done and the cost involved. Hospitals and physicians across this country are including the prices of antibiotics on the sensitivity reports that come back from the laboratory.

A great spate of articles in the medical literature by physicians raise questions about various types of technology that have been introduced, trying to determine through scientific studies whether they have value or not. The AMA's program on technology assessment has a panel of 900 medical experts across the country that try and help us review new developments in technology and decide whether or not they have value.

I wish I could sit here and tell you I have the answer for the economic bottom line but I do not believe that perfection has been reached. There is a great deal to be done in the future, and I do believe physicians have and are increasingly becoming aware of the need to look at what they are doing and how much they are doing it.

Mr. **Duncan**. You have heard a certain amount of bashing here today, if you have been here very long, about physicians. Would you care to comment?

Dr. **Todd**. I am sorry.

Mr. **Duncan**. I said we have had a little physician bashing here today. Do you care to comment on any of the statements you might have heard today?

Dr. **Todd**. We are not going to be paranoid over that. I think everybody realizes that there is a difficult problem. Everybody is coming from a different direction, a different point of view, trying to reach a conclusion that we all want. The problem is how do you do it without infringing either on the quality of the care, the access of the care, or the prerogatives of the providers of care.

Mr. **Duncan**. We are starting to get a lot of complaints, and I say we have not heard anything yet, from senior citizens particularly, on the catastrophic health bill and its prescription drug component. When senior citizens get the bill for castastrophic coverage, today's increases in part B spending will look minute compared to that.

Dr. **Todd**. There is no question about that and one of our concerns is that a lot of these people, as they see the costs, are going to drop out of part B and then will join that growing rank of the under-insured or uninsured and add to the problem of uncompensated care that you know is currently driving hospitals up the wall.

Mr. **Duncan**. That is one of the fears some of us have. May I again thank you. I think you made a good statement and thank you, Mr. Chairman.

Mr. **Stark**. Mr. Gregg.

Mr. **Gregg**. I have no questions.

Mr. **Stark**. Mr. Daub.

Mr. **Daub**. Thank you, Mr. Chairman.

I appreciate your statement and the attention that you indicate that professional physicians are willing to devote to their responsibilities. Along with Mr. Pickle, I, from time to time, take a look at the inside activity of a physician's office and I am impressed, I must say, by the number of physicians in this company who, while they may not take payment under mandatory assignment do, in fact, on an assessment of the financial circumstances of their patients, accept the Medicare payment as payment in full.

I happen to share your view that with the growing number of elderly and with the degree of modern technology that has come into the marketplace that if you have a double, or a triple or a quadruple bypass or you have had a hip replacement or some other more complicated surgery you tend, in your own right, to want to come into the office more.

You are not in the hospital as much anymore, but you tend to want to come in and make sure that everything is going okay, so that utilization, given the technology that is in the marketplace, plus the degree of increase in numbers of beneficiaries necessarily leads to increased program costs. And while we may not know exactly what proportion of the premium increase might account for these factors, the increase has got to amount to more than this committee may be willing to speculate upon or that even the experts today know enough about to say.

I hope you will work with us and encourage your physician members to work with us to be sure that quality health care continues to be broadly available and that we do not reach the point that the premium will be so high that we will start to lose people because their light bill and their heat bill and their grocery bill tend to be more immediate needs and because they are on fixed income or they are near poor, they choose not to take part B.

That would be a tragedy of the largest proportion, and we are going to need your help to make sure that that does not happen.

Dr. Todd. We are here to give it to you in every way that we can, because I think we share that same concern. You are absolutely right, the sooner a patient leaves the hospital there is an increase in anxiety—and I was a surgeon in New Jersey and I lived through DRGs before they became a Federal program, so I have longer experience with DRGs and the resulting anxiety.

I am not saying that these patients should not be sent home. However, they were sent home less well recovered than other patients and there was an increase in the anxiety level of these patients at home. Patients leave the hospital with dressings, with sutures still in place that have to be removed, without the 24 hour support, and there is no question that these patients need to be seen more often by more people and that the communities, in many respects, were not prepared to receive these people back into the community. All of this increased nonhospital health care expenditures, whether out of part B or whether out of some other health program.

Mr. Daub. Of course, Doctor, the misestimation of what the actual cost of the premium ought to have been a year ago and this year has certainly compounded the alarm that all of us have with respect to the costs for next year. Had we done our jobs better in government, perhaps the pain would have been spread around a little bit or spread out or stretched out and we would not have such an emotional reaction to what is going on right now.

Thank you for your testimony, Doctor.

Dr. Todd. Thank you.

Mr. Stark. Mr. McGrath.

Mr. McGrath. I have no questions, Mr. Chairman.

Mr. Stark. Dr. Todd, you have testified eloquently that, in your opinion, this increase in the premium is not the fault of the doctors. Is there any question in your mind, that approximately 75 percent of all of the part B payments go to the doctors?

They are getting it, is that not correct?

Dr. Todd. Let me clarify what I really said.

Mr. Stark. Just answer my question. You can clarify later. Is there any quarrel that about 75 percent of what we pay out in part B payments goes to the doctors?

Dr. Todd. No, and there is no quarrel that physicians control, by their decisions, essentially the bulk of health care expenditures.

What I did not say was that physicians were not responsible in some respects in their decisions. What I said was that their fees were not responsible for the increase.

Mr. Stark. But their gross receipts are the result of the increase?

Dr. Todd. Yes.

Mr. Stark. These payments have been going up 14 to 17 percent, depending on how you look at it, over the last 5 years. Let us set that aside. That we know.

That is higher than any other inflation index, whether it's the Consumer Price Index or another measurement, is that not correct?

Dr. Todd. That is correct. But I would also want to point out that they are buying a different product. There are more people involved and to compare——

Mr. **Stark.** I will stipulate all that. I have no quarrel. I am suggesting that the rate of increase is higher than the cost of insurance, automobiles, food or other things and as a practical matter, of all the industrialized nations in the world, we in the United States pay a larger share of our gross national product for medical services and I would suspect for physician's services, also.

Let us assume for a minute that the public is concerned about paying for this increase, whether we pay for it through the part B premium or whether it comes out of the general revenues. It is the White House, as you know, that has suggested the freeze. I am not sure the AMA is aware of this, but in the past they also suggested the freeze in physician's payments.

I might add, it is this committee that has contravened that suggestion and maybe not given them as much of an increase as they want, but we gave them some.

Let us assume for a minute that we are to obey the law next year and limit the part B increase in the beneficiaries payment to the COLA. And let us assume for a minute that is 4 percent.

Now let us further assume that in our efforts to hold down the budget we decide to limit total part B expenditures to a 4-percent increase. You and I both know that for 5 or 10 years it has been two, three and four times that amount each year.

How would you suggest, without further studies or other deliberations, we move from what we anticipate might be a 12 to 14 percent increase next year if we do not do anything? How can we cut that down to 4 percent? What can we do? What is a quick fix?

Dr. **Todd.** Let us make the assumption that most of the figures are correct and that most of the increase in volume is justified. Can we make those assumptions?

Mr. **Stark.** I will not agree to that because I have had no testimony to that effect.

Dr. **Todd.** Take half of the 9 percent that we cannot really explain. Now if you say that the health care system, the Medicare system, has to be limited to the COLA there are relatively few options. You have to reduce benefits. You have to reduce the frequency with which patients may be seen. You have to reduce the reimbursement to physicians.

And there has to be an educational process because if you think you are getting a lot of letters now because the premiums are going up, if you start reducing benefits or if an area under capitation has run out of money and cannot produce the sort of care that some of those patients need, you are going to get a lot more letters that are going to be a lot harder to respond to.

Our concern is that, if you have got to reduce the expenditures, then let us do it in a fashion that everybody understands. Beneficiaries should not suddenly, after the fact, get denials for care that they have received and that has been given in good faith. Let us make sure that everybody understands what is being done, how much is going to be done, and how much each segment of the population is going to have to contribute to the control of these costs.

Mr. **Stark.** How much do you think the physicians should contribute?

Dr. **Todd.** We can debate this for a long period of time, but I would suggest to you that if the physician's fee is reasonable and

Congress is mandating what the individual physician's reimbursement shall be or what the level of increase shall be——

Mr. STARK. What about his gross income?

Dr. TODD. That is what I am getting at, that if you agree that the fee is reasonable and if you agree that the care is necessary and of quality, the physician's total income should not be of any concern to you because some physicians will work 40 hours a week and some physicians will work 50 hours a week and some may even work 70 hours a week.

It seems to me all of our concerns should focus on the service being fairly priced, appropriately given and be of quality. The total income of a physician depends upon his or her industry.

Mr. STARK. So you, in effect, think that we should continue under the fee for services plan. I do not think you leave us much choice, and I do not know if that helps us any.

Dr. TODD. No, I am not sure it does either, but I think what I am trying to get at is that there is no quick fix. There is not anything that can quickly be done that is not going to carry risk. As recently described in the Wall Street Journal, this becomes like a balloon: you push it in one place and it pops out in another.

We would like to find a way to contain this whole thing. The payment commission is working on it, Congress has mandated a relative value study. Everybody is now looking at volume. These are all things that are going on and while we can sympathize with your problems and need to do something, we also are concerned that something will be done that will preclude a long term solution or something will be done causing irreparable harm either to the providers or to the beneficiaries. You really do not want that to happen to either one.

Mr. STARK. I do not want it to happen to the beneficiaries, in the first order of business. And quite frankly, I do not know that the providers who enjoy the highest incomes of any group in this country for no good reason, should not be brought more into line.

Dr. TODD. I do not want to appear parochial, Mr. Stark, but I think that physician's income, as I said—if they provide services at reasonable fees and of quality—the level of their income depends upon their industry. You say that they have the highest income for no good reasons.

Take into account the length of education of a physician, the fact that they do not begin to earn—I did not begin to earn any sort of an income until I was 35 years old.

Mr. STARK. That is not my fault.

Dr. TODD. I know that is not your fault, but I think that I have a shorter period of time in order to be able to prepare to educate my children, prepare for my retirement and, if I am a private practitioner, I have no corporation, no stock options, nothing behind me like the perks that many business people have.

So, as I say, the validity of a physician's income ought to be determined on the equity of their services and the level of their industry and not by comparison with anything else. I can show you some physicians that are having a very hard time making ends meet. I can also show you some physicians that are making obscene incomes.

But on balance, we are talking about some very serious professionals and I am sure, as a professional yourself, you share the concerns that you perform in your profession to the best possible degree. And I think that is what the average physician out there is doing.

Mr. **Stark**. I have no quarrel that they perform. I just submit that I can find many of them, for example, HMOs, that can provide high quality care at a fraction of the cost of fee for service. That means physicians on salaries and I submit to you that the salaries for those physicians in HMOs are somewhat lower than the $112,700 net after expenses, that other physicians receive.

Mr. **Blehart**. Mr. Chairman, when you talk about those salaries——

Mr. **Stark**. I am directing my questions to Dr. Todd, thank you.

As I say, I do not hope to get much help out of the physicians. I think that your position is clear, and that is that everybody else should suffer financial hardships but the physicians should earn all they can get out of the system. I am not surprised to see that the AMA position has not changed much in 50 years and I doubt if it ever will.

I thank you for your testimony.

Dr. **Todd**. I suspect you and I will disagree on that for a long period of time, but I think the final answer on HMOs is not in. There also is no question that the physician salaries——

Mr. **Stark**. Whether you agree with me or not, Doctor, is a matter of great indifference to me, thank you.

Our next witness, is Mr. Jack Guildroy, representing the American Association of Retired Persons.

STATEMENT OF JACK GUILDROY, MEMBER, NATIONAL LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY STEPHANIE KENNAN, FEDERAL AFFAIRS STAFF

Mr. **Guildroy**. Mr. Chairman, my name is Jack Guildroy. I am a member of the national legislative counsel of the American Association of Retired Persons which represents over 26 million members and with me is Stephanie Kennan of AARP's Federal affairs staff.

I represent the consumers and the elderly on the Physician Payment Review Commission, but in this testimony I represent only AARP.

The projected 38.5 percent increase in the port B premium is frustrating and alarming to beneficiaries because it is a sign of a health care system out of control. I am submitting for the record a fact sheet showing beneficiary liability for physician's services.

Nearly all beneficiaries pay the part B premium which has increased nearly 150 percent since 1977. Premiums for other health care insurance are also increasing at a rapid rate. In the case of federal employee health plans, about 30 percent.

The latest crisis cannot be blamed on beneficiary behavior. During the past decade, the number of physician office visits per enrollee has remained relatively stable. What has changed is the number of services and of price per service. These are two factors beneficiaries do not control.

They are willing to pay their fair share of the cost of Medicare, but they cannot accept an open-ended liability. If the projected increase does occur, the number of beneficiaries with no cost of living adjustment will grow from 600,000 this year to 742,000 next year. These beneficiary Social Security checks will not decrease because current law will hold them harmless. The growing number of beneficiaries in this category could jump dramatically if the same conditions for 1988 occur again in 1989.

[The following was subsequently received:]

AMERICAN ASSOCIATION OF RETIRED PERSONS,
Washington, DC, November 18, 1987.

Hon. DAN ROSTENKOWSKI,
Chairman, House Ways and Means Committee, U.S. House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: On September 30, 1987, the American Association of Retired Persons (AARP) testified before your committee concerning the Part B premium increase for 1988.

At that time we testified that approximately 742,000 beneficiaries would not receive a Social Security cost-of-living-adjustment (COLA) because of the size of the scheduled premium increase.

We have recently refined our estimates. After taking into account the manner in which the Social Security Administration is required to round beneficiaries' checks under Sections 215(g) and 1839(c) of the Social Security Act, it appears that an additional 878,800 beneficiaries will also not receive a COLA. This brings the total number of beneficiaries not receiving a COLA to about 1.6 million in 1988.

Attached is a chart detailing this information. If the hearing record is still open we would appreciate the inclusion of this revised data.

Thank you for your attention to this important issue.

Sincerely,

MARTIN A. CORRY,
Director, Federal Affairs.

COST OF INCREASED MEDICARE PART B PREMIUM, 1988 NUMBER OF BENEFICIARIES NOT RECEIVING COLA

SMI enrollees	Average monthly Social Security	4.2 percent COLA	Total benefit rounded	Part B premium increase	Benefit change	Total cost
2,900	$5	0.21	$5.20	6.90	−6	19,430
3,800	15	0.63	15.60	6.90	−7	23,940
4,300	25	1.05	26.00	6.90	−6	25,370
7,500	35	1.47	36.40	6.90	−6	41,250
9,700	45	1.89	46.80	6.90	−6	49,470
15,300	55	2.31	57.30	6.90	−5	70,380
15,700	65	2.73	67.70	6.90	−5	65,940
44,300	75	3.15	78.10	6.90	−4	168,340
43,900	86	3.61	89.60	6.90	−4	144,870
45,900	96	4.03	100.00	6.90	−3	133,110
59,400	106	4.45	110.40	6.90	−3	148,500
54,000	116	4.87	120.80	6.90	−3	113,400
85,800	126	5.29	131.20	6.90	−2	145,860
117,200	;136	5.71	141.70	6.90	−2	140,640
116,400	146	6.13	152.10	6.90	−1	93,120
116,200	157	6.59	163.50	6.90	−1	46,480
282,700	167	7.01	174.00	6.90	0	0
234,900	177	7.43	184.40	6.90	0	0
361,200	187	7.85	194.80	6.90	0	0
324,000	197	8.27	205.20	6.90	1	0
717,500	207	8.69	215.60	6.90	1	0

COST OF INCREASED MEDICARE PART B PREMIUM, 1988 NUMBER OF BENEFICIARIES NOT RECEIVING COLA—Continued

SMI enrollees	Average monthly Social Security	4.2 percent COLA	Total benefit rounded	Part B premium increase	Benefit change	Total cost
315,000	217	9.11	226.10	6.90	2	0
376,800	227	9.53	236.50	6.90	2	0
419,300	238	10.00	247.90	6.90	3	0
459,700	248	10.42	258.40	6.90	3	0
Monthly cost						1,430,100
Annual cost						17,161,200

Note.—Persons W/no COLA: 1,621,100.

Mr. GUILDROY. Also, about 750,000 beneficiaries will have their COLA reduced to one dollar or less because of the large premium increase.

What can be done to protect both beneficiaries and the U.S. Treasury from runaway costs and steep increases in part B premiums? In the long run, we should bring increases in part B in line with increases in general inflation. The current controversy makes physician payment reform even more urgent.

Payment reform must create fair and objective payments but should also protect beneficiaries from large unpredictable out of pocket costs without creating barriers to care.

AARP supports a resource based relative value scale to achieve this goal. We also support mandatory assignments when fair payments are created. But this alone will not address the issue of intensity of services.

Utilization controls based on patient outcomes must be developed and implemented. We have no scientific data that shows that an increase in intensity of services appreciably improves the health status of beneficiaries. Congress and beneficiaries must question what value we are receiving for our money.

While considering payment reform, we urge Congress to keep in mind the size of the cost of living adjustment beneficiaries receive and devise a rule of thumb by which the premiums should rise. The premiums should not necessarily be pegged to the cost of living adjustment, but the premium increase should not be so far in excess of this amount.

Meanwhile, we urge Congress to do certain things. First to determine the appropriate level of the reserve and then the rate at which the reserve should be billed. Program managers have a responsibility to determine this accurately. When decisions are made causing the reserve level to drop dangerously low, the reserves should be replaced but not so quickly as to impose a hardship on beneficiaries.

Beneficiaries appreciate the fact that there was no premium increase in 1986 but now are playing catchup for that decision. We are trying to catch up in one large leap.

Second, Congress should pass pending budget reconciliation legislation that achieves short term savings in Medicare while protecting beneficiaries from further cost shifting.

Third, Congress should strengthen the way in which beneficiaries can limit their liability for physician services until real reforms are achieved. The participating physician program is one such way, but there is still great variation by specialty and geographic location.

AARP supports this committee's recommendation to give participating physicians favored treatment in the updating next year.

Last, we urge Congress to focus on physician payment reform as soon as possible, and we look forward to working with you on this most challenging issue.

Thank you, Mr. Chairman.

[The statement of Mr. Guildroy follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

INCREASES IN MEDICARE PART B PREMIUMS

before the

HOUSE COMMITTEE ON WAYS AND MEANS

Washington, D.C.
September 30, 1987

Presented by:

Jack Guildroy
Member, AARP National Legislative Council

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

John T. Denning *President* Cyril F. Brickfield *Executive Director*

Mr. Chairman, my name is Jack Guildroy. I am a member of the National Legislative Council of the American Association of Retired Persons (AARP) which represents over 26 million members. I represent the consumers and the elderly on the Physician Payment Review Commission, but today I am not representing the commission.

The projected 38.5 % increase in the Part B premium is alarming and frustrating to beneficiaries because it is a symptom of an out of control health care delivery system. I would like to submit for the record a fact sheet on "Medicare Beneficiary Liability for Physician Services" prepared by AARP's Public Policy Institute which demonstrates the effect of our current payment policies on beneficiaries.

Beneficiary Liability for Part B

Nearly all beneficiaries pay the Part B premium which has been rising steadily. The 1987 annual premium was an increase of 15% over 1986. Part B outlays jumped 20% in the past year. If the projected 38.5% premium increase does occur then the cumulative increases in the premium will equal 150% since 1977. In contrast next year's Social Security cost-of-living-adjustment (COLA) is expected to be only 4.2%.

In addition to the premium, beneficiaries have other liabilities related to Part B. The Part B deductible of $75 actually represents about $100 in out-of-pocket costs because only Medicare's allowed charges count toward the deductible and the average reduction on Part B claims is about 26.5 percent. Beneficiary liability for the 20% Part B co-insurance more than doubled between 1980 and 1984 and rose from 20% of overall liability to 32% between 1975 and 1985. Despite increased acceptance of assignment, charges associated with non-assigned claims totaled $2.6 billion in 1985 - an increase of 100% since 1980. In addition there is enormous variation in assignment rates by state and physician speciality - factors over which patients have no control.

Health Care Costs

Skyrocketing costs afflict all aspects of fee-for service medicine. Unprecedented increases in program costs are not limited to Medicare; federal employees' health insurance premiums are also going up about 30%. HMO's with medicare risk contracts whose increases are based on fee-for-service costs in their specific areas are receiving an average increase in payment of 13.5%. In contrast, HMO premiums not based on the fee-for-service sector are expected to rise much more slowly next year.

The cause of this latest crisis in Medicare cannot be attributed to beneficiary behavior. Government statistics show that the average annual number of physician office visits per enrollee has been virtually the same for the past decade. This figure is approximately 5 office visits per enrollee. What has changed is the price and intensity of services provided during these visits. These two factors - the intensity and price of services - jointly account for most of the historic increases in Part B outlays. Beneficiaries do not control either of these factors.

Let me stress that beneficiaries are willing to pay their fair share of the cost of Medicare, but cannot accept an open-ended liability over which they have no control.

If the projected increase of over 38% in the premium occurs, approximately 742,000 beneficiaries receiving Social Security checks will fall under the current "hold harmless" provision. This provision prevents the Social Security check from dropping in instances where the cost-of-living adjustment is less than the premium increase. These beneficiaries, in effect will not see a COLA. In 1986 approximately 600,000 beneficiaries were held harmless. If the Part B premium were to rise the same amount again in 1989, and beneficiaries received the same 4.2% COLA, the number of beneficiaries held harmless would be over 3 million.(see charts 1 & 2).[1]

In 1988 an additional 750,000 beneficiaries will have their COLAs reduced to $1 or less in effect because the premium increase will take the majority of their COLA.

Program Management

Run away costs and cost-shifting are signs of a poorly managed program. An issue which must be addressed is the role of the SMI reserve and the way in which the reserve interacts with the calculation of the Part B premium. In 1986 there was no increase in the premium and now we are told that part of the projected increase for 1988 is partially due to a miscalculation and the need to rebuild the reserves.

Medicare's program managers have a responsibility to determine the proper level of the reserve fund to cover expected expenses. The amount of reserves has fluctuated historically. While management has an obligation to restore the reserve to an acceptable level, this should be done gradually so a hardship is not imposed on beneficiaries. For example, the 1983 Social Security Amendments permitted the OASDI trust fund reserve to be built up at a gradual rate. This approach should be adopted in order to build the reserve without burdening beneficiaries for management mistakes.

In addition, our current health care system fails to control utilization effectively. Physicians in the fee-for-service sector have a blank check. The physician determines the clinical management of the patient's case - what tests and procedures are to be done. We need to determine how much the unbundling of services - charging for each step in a service rather than the whole package has also contributed to the increase in volume and therefore program costs. In neither instance does the beneficiary have control over those decisions. Beneficiaries and Congress need to ask what value we are receiving for our money.

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[1] Some, of these small check beneficiaries may be Medicaid dual-eligibles, for whom the premium is paid, though the precise number is is not apparent to us.

Physician Payment Reform

Congress identified the need for physician payment reform under Medicare when it created the Physician Payment Review Commission to create a blueprint for reform. This current crisis makes that reform all the more necessary and urgent.

The Association firmly believes that Part B of Medicare must be reformed as quickly as possible to achieve the following long-term goals:

1. Protect beneficiaries from large and unpredictable out-of pocket costs;
2. Control program outlays so increases are more in line with general inflation;
3. Reform physician payment so that fees are based on a resource based relative value scale with increased payments for undervalued services such as nursing home visits and primary care of those with multiple chronic conditions;
4. Deliver medically necessary and appropriate care by developing utilization controls based on quality of patient outcomes.

Our recommendations for payment reform are based on several important principles. First, reduced Medicare payments for physician services, such as those adopted under the rubric of "inherent reasonableness", should not result in cost-shifting to beneficiaries. Unless these reductions are accompanied by statutory limits on balance billing, this inevitably will occur. We favor the approach to limits on payments like those Congress adopted for cataract surgery in the FY 1987 Budget Reconciliation Act. Beneficiaries already directly pay about $3 billion for physician fees in excess of Medicare's allowed amount. Beneficiary liability will surely skyrocket if Congress and the Physician Payment Review Commission pursue program savings without including protections from balance billing on unassigned claims.

Second, revision of Medicare's physician payment system should not just satisfy physician perceptions of fairness and rationality. A truly meaningful payment reform must also limit beneficiary liability to predictable and manageable amounts. In our view, there is no reason why physicians ought not to accept Medicare's allowed fee as payment in full if that amount is based on a system that is objectively fair and reasonable. That is, mandatory assignment should be a component of a reformed Part B payment method.

The Association approaches the issue of mandatory assignment absent fee reform with caution because of the risk of creating access problems for beneficiaries residing in areas with low assignment rates and low physician/population ratios.

Third, efforts to control Part B expenditures must be designed to ensure that Medicare payments are not set so low that access to care is jeopardized.

Fourth, since a large component of increased outlays for physician services is an increased number and intensity of services per physician contact, utilization review must accompany cost control lest physicians off-set lower fees by higher volume of services. There is little evidence that increased intensity of physician services has appreciably improved the health status of beneficiaires.

Organized medicine for many years has stated that it can police itself. We suggest that beneficiaries, physicians and Congress cooperate to address these needs - protection from an increasing beneficiary liability, fair fees and reduced program costs. An individual physician cannot change the net negative effects of the current program. Organized medicine must begin to play a more cooperative role in developing utilization controls for the delivery of services which will increase the quality of care as well as holding the line on program costs.

Interim Measures

As physicians, beneficiaries and Congress begin to address the issues of physician payment reform, AARP recognizes that much of what is needed to improve the system cannot be done instantly. Interim steps are needed.

We encourage Congress to consider the following:

1. Determine an adequate and desirable SMI reserve level and mandate a gradual rate of increase to build the reserve that would not impose an undue burden on beneficiaries.

2. Passage of pending budget reconciliation legislation to achieve short-term savings in Part B. This should have some impact on the premium since it will reduce program outlays

3. Strengthening of the participating physician program. While this does not address the increase directly, it would provide beneficiaries an opportunity to control the out-of-pocket costs they incur for physician service. Efforts should be targeted at States and specialties with low assignment rates. We oppose penalties on beneficiaries for failure to use participating physicians. Beneficiaries have no power over the physician's decision whether or not to participate and changing physicians solely on the basis of price could seriously disrupt the continuity of our care and be a hardship on patients.

Finally while the idea of directories of participating physicians is laudable, they must be monitored for accuracy otherwise they will be of little use in selecting a physician on the basis of his or her assignment practices. I have found my directory to be inaccurate and think my experience may not be unusual.

Conclusion

Congress cannot permit Medicare program costs to continue unchecked. We hope that this latest controversy will force action on physician payment reform earlier than otherwise might have occured.

As Congress looks at overall reform of the Part B program, we believe that you must also take into account how fast premiums will rise. Congress must weave into its reforms a rule of thumb of how much the Part B premium will be permitted to increase even after reform takes place. In developing this guideline, Congress should also take into account the amount of the cost-of-living-adjustment beneficiaries receive.

Premium increases should not necessarily be pegged to the COLA, but they should not rise at a rate far in excess of the COLA as will be the case this year.

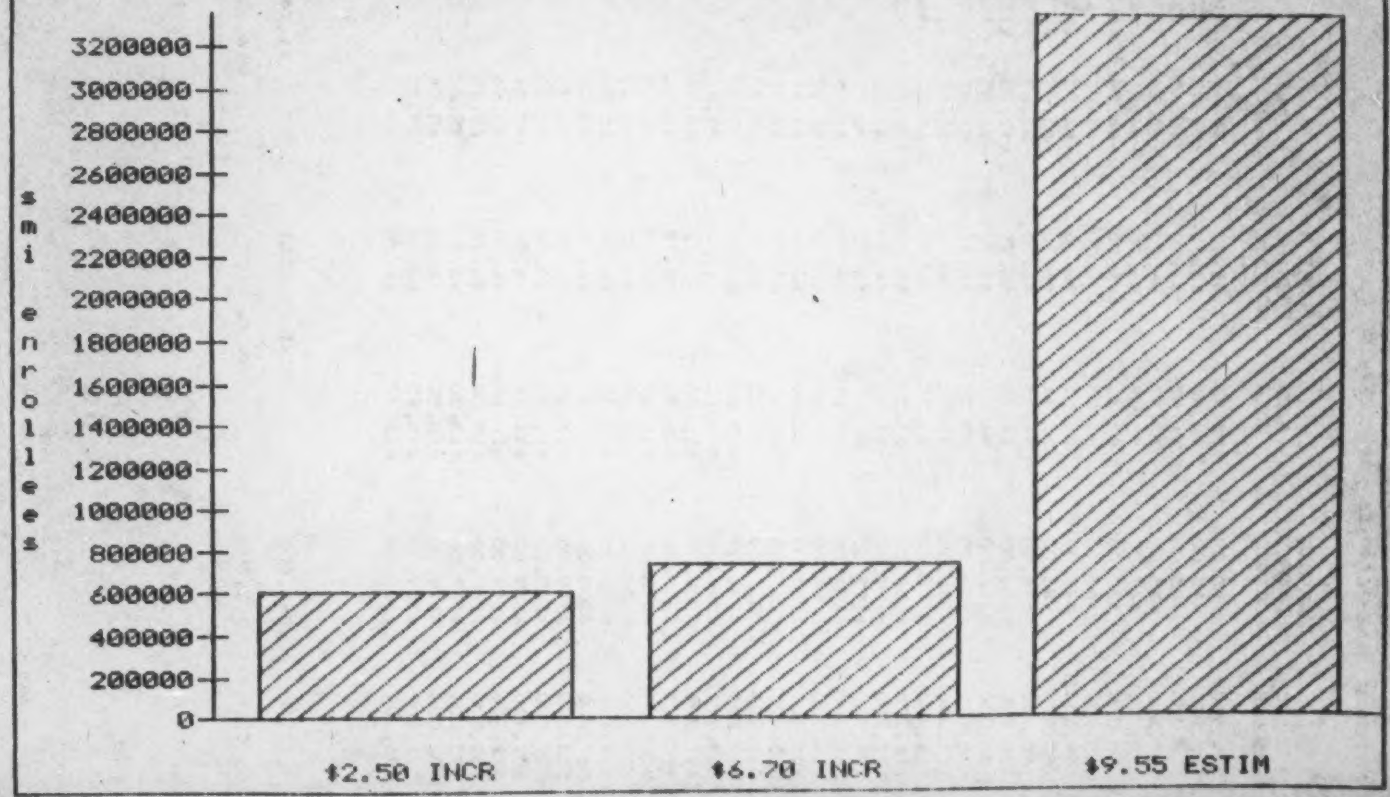
The issue of volume and the unbundling of services must become the top priority of Congress in addressing this crisis on a long term basis. A resource based relative value scale alone will not address the volume issue.

The Association looks forward to working with Congress in determining how to deliver cost-effective quality care to Medicare beneficiaries. This challenge will not only affect current beneficiaries, but many generations to come.

COST OF INCREASED MEDICARE PART B PREMIUM, 1988
NUMBER OF BENEFICIARIES NOT RECEIVING COLA

SMI ENROLLES	AVERAGE MONTHLY SOC SEC	4.2% COLA	PART B PREMIUM INCREASE	NET CHANGE	TOTAL COST
2,900	$5.00	$0.21	$6.70	-$6.49	$18,821.00
3,800	$15.00	$0.63	$6.70	-$6.07	$23,066.00
4,300	$25.00	$1.05	$6.70	-$5.65	$24,295.00
7,500	$35.00	$1.47	$6.70	-$5.23	$39,225.00
9,700	$45.00	$1.89	$6.70	-$4.81	$46,657.00
15,300	$55.00	$2.31	$6.70	-$4.39	$67,167.00
15,700	$65.00	$2.73	$6.70	-$3.97	$62,329.00
44,300	$75.00	$3.15	$6.70	-$3.55	$157,265.00
43,900	$86.00	$3.61	$6.70	-$3.09	$135,563.20
45,900	$96.00	$4.03	$6.70	-$2.67	$122,461.20
59,400	$106.00	$4.45	$6.70	-$2.25	$133,531.20
54,000	$116.00	$4.87	$6.70	-$1.83	$98,712.00
85,800	$126.00	$5.29	$6.70	-$1.41	$120,806.40
117,200	$136.00	$5.71	$6.70	-$0.99	$115,793.60
116,400	$146.00	$6.13	$6.70	-$0.57	$66,115.20
116,200	$157.00	$6.59	$6.70	-$0.11	$12,317.20
→ 282,700	$167.00	$7.01	$6.70	$0.31	$0.00
234,900	$177.00	$7.43	$6.70	$0.73	$0.00
361,200	$187.00	$7.85	$6.70	$1.15	$0.00
324,000	$197.00	$8.27	$6.70	$1.57	$0.00
717,500	$207.00	$8.69	$6.70	$1.99	$0.00
315,000	$217.00	$9.11	$6.70	$2.41	$0.00
376,800	$227.00	$9.53	$6.70	$2.83	$0.00
419,300	$238.00	$10.00	$6.70	$3.30	$0.00
459,700	$248.00	$10.42	$6.70	$3.72	$0.00
491,500	$258.00	$10.84	$6.70	$4.14	$0.00
485,900	$268.00	$11.26	$6.70	$4.56	$0.00
502,100	$278.00	$11.68	$6.70	$4.98	$0.00
563,600	$288.00	$12.10	$6.70	$5.40	$0.00
533,100	$298.00	$12.52	$6.70	$5.82	$0.00
550,400	$308.00	$12.94	$6.70	$6.24	$0.00
533,000	$319.00	$13.40	$6.70	$6.70	$0.00
539,500	$329.00	$13.82	$6.70	$7.12	$0.00
487,900	$339.00	$14.24	$6.70	$7.54	$0.00
478,400	$349.00	$14.66	$6.70	$7.96	$0.00
502,500	$359.00	$15.08	$6.70	$8.38	$0.00
473,800	$369.00	$15.50	$6.70	$8.80	$0.00
472,000	$379.00	$15.54	$6.70	$8.84	$0.00
521,600	$389.00	$15.95	$6.70	$9.25	$0.00
496,300	$400.00	$16.40	$6.70	$9.70	$0.00

TOTAL	11,865,000	MONTHLY COST	$1,244,125.00
NO COLA	742,300	ANNUAL COST	$14,929,500.00



PERSONS RECEIVING NO COLA, 1987--1989
(1989 ASSUMES 1988 RATE INCREASE)

AARP PUBLIC POLICY INSTITUTE ISSUE BRIEF

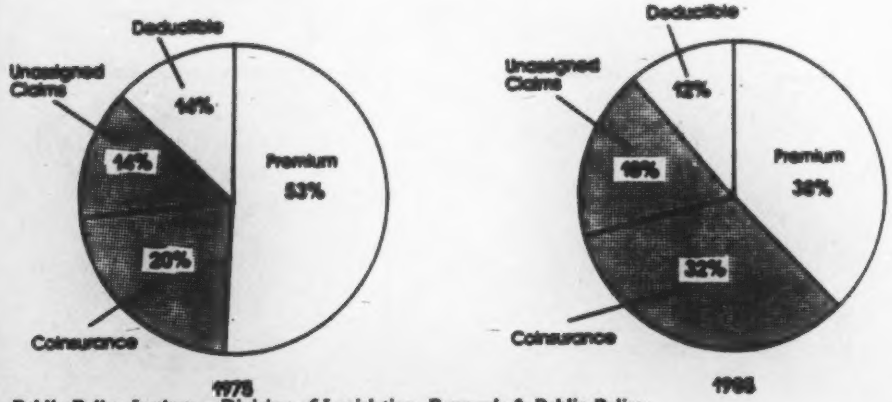
FACT SHEET

MEDICARE BENEFICIARY LIABILITY FOR PHYSICIAN SERVICES

I. Liability for Medicare-Covered Physician Services

Medicare beneficiary liability for physician services consists of four components: Part B premium payments, an annual deductible, coinsurance, and charge reductions on unassigned claims. The relative contribution of these four categories to total beneficiary liability for physician services has shifted over time. In 1975, premium and deductible expenditures represented 67% of total beneficiary liability for physician services. By 1985, coinsurance and charge reductions, two categories of expenditure which are essentially unpredictable, played as significant a role in total physician service liability as premiums and deductibles.

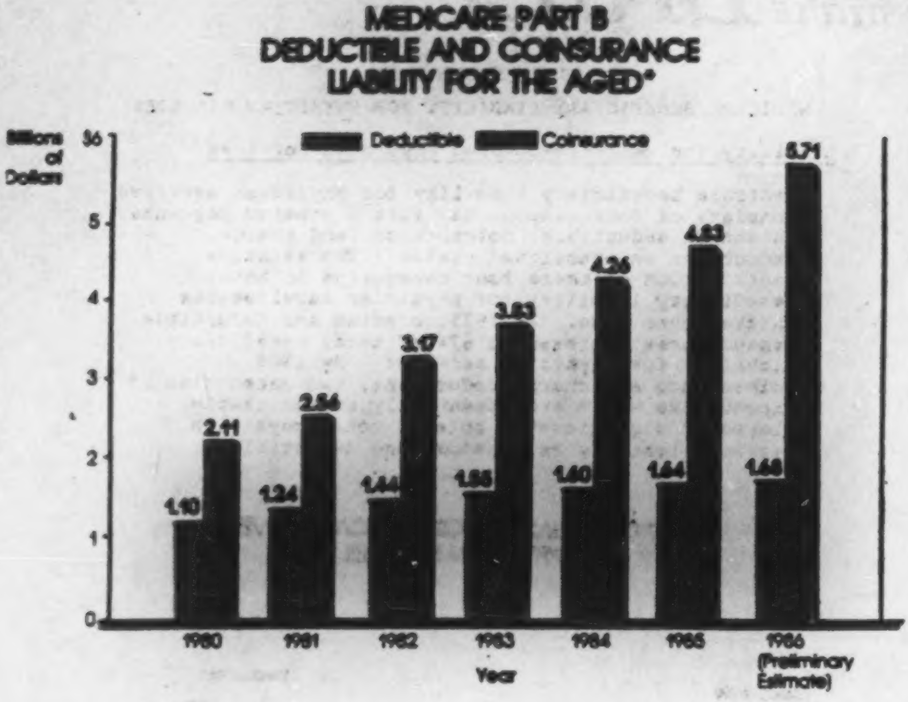
BENEFICIARY LIABILITY FOR MEDICARE-COVERED PHYSICIAN SERVICES



Public Policy Institute • Division of Legislation, Research & Public Policy
American Association of Retired Persons • 1909 K Street, N.W., Washington, DC 20049 • (202) 872-4700

Source: HCFA

Beneficiary payments for the four categories of liability for Medicare-covered physician services have risen steadily. The following charts track increases in liability components since 1980.

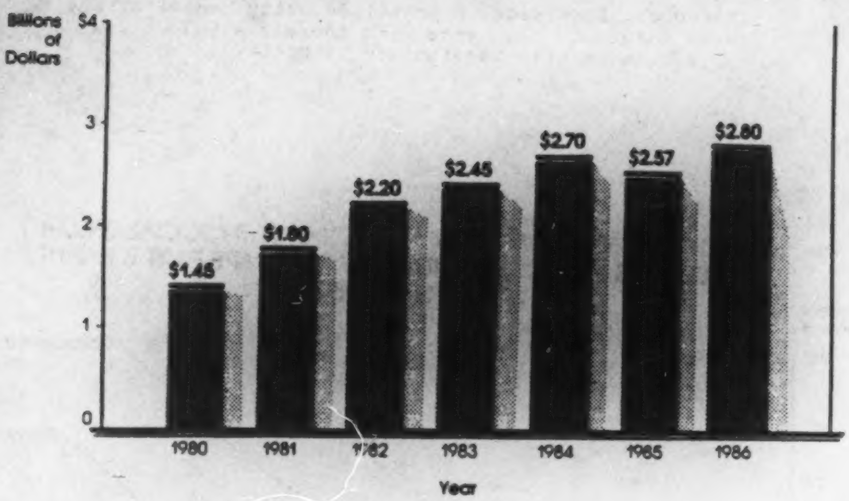


MEDICARE PART B DEDUCTIBLE AND COINSURANCE LIABILITY FOR THE AGED*

*Includes Physicians and Other Medical Suppliers

Source: HCFA, Office of the Actuary, January 1987

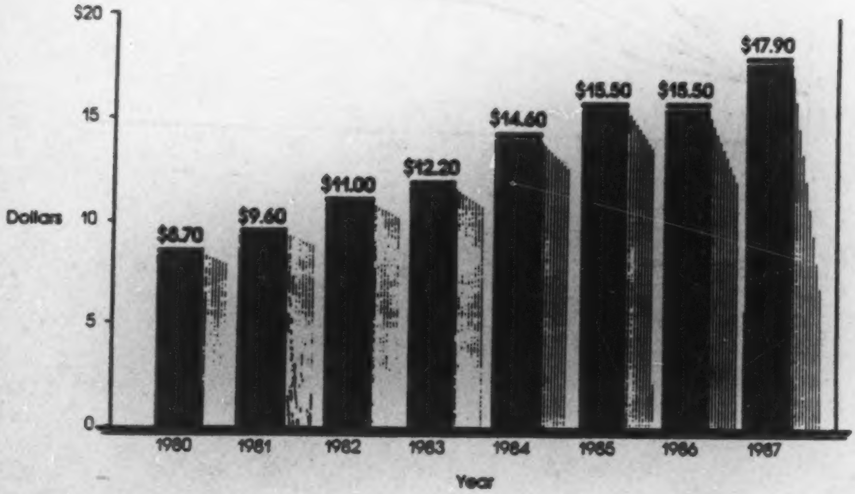
CHARGE REDUCTIONS ON UNASSIGNED MEDICARE PART B CLAIMS*



*Includes Physicians and Other Medical Suppliers

Source: HCFA

MEDICARE PART B MONTHLY PREMIUM

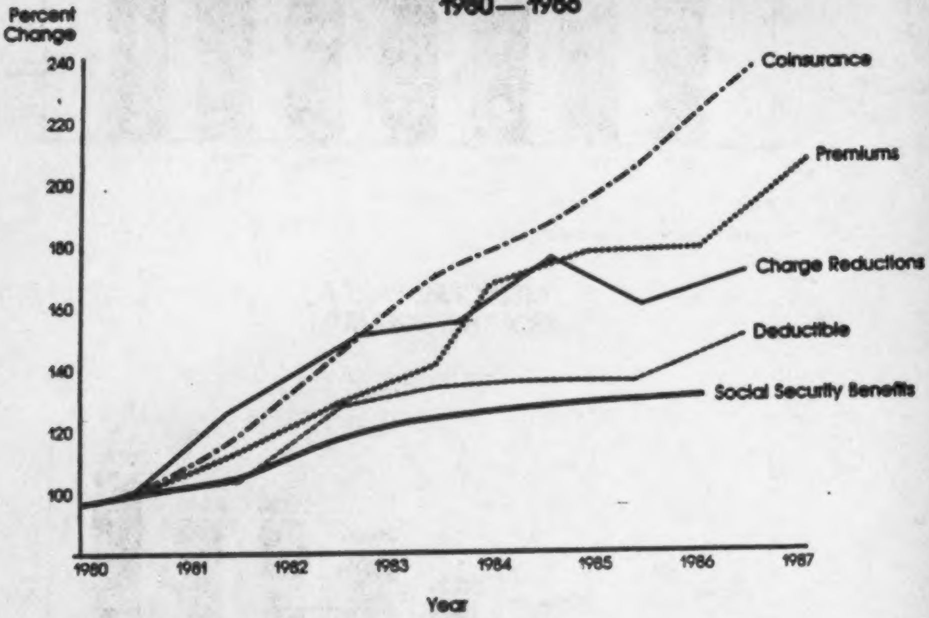


Source: Trustees' Report, April 1986.

While there have been significant increases in all four categories of liability stemming from the use of physician services, there has also been considerable variability in the rate of increase among the four liability components.

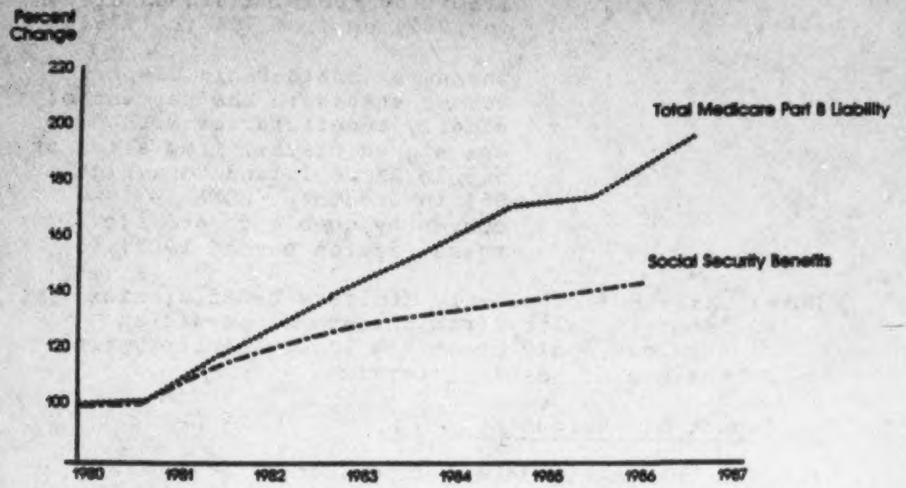
Moreover, increases in Social Security benefits have been unable to keep pace with increases in physician-related beneficiary liability.

COMPARISON OF CUMULATIVE CHANGE IN SOCIAL SECURITY BENEFITS AND COMPONENTS OF MEDICARE PART B LIABILITY 1980—1986



Source: HCFA: Social Security Bulletin

COMPARISON OF CUMULATIVE CHANGE IN SOCIAL SECURITY BENEFITS AND TOTAL MEDICARE PART B LIABILITY 1980—1986



Source: HCFA; *Social Security Bulletin*

II. **Who is Affected?**

o **Part B Premium:**	**97% of elderly Medicare beneficiaries purchase Medicare Part B coverage.**
o **Deductible:**	**80% of elderly Medicare beneficiaries make payments toward the deductible for physician services.**
o **Coinsurance:**	**60% of elderly Medicare beneficiaries use Medicare-reimbursed services, thereby triggering coinsurance liability.**

- Charge Reductions on Unassigned Claims: 80% of elderly Medicare beneficiaries with reimbursement for physician services had some liability from unassigned claims in 1982, up from 70% in 1975.

  There is considerable disparity across states in the percent of elderly beneficiaries with unassigned claims, from a low of 51% in Rhode Island to a high of 95% in Oregon. (HCFA is currently unable to provide these figures beyond 1982).

Note: While 80% of elderly Medicare beneficiaries incur liability from the use of physician services, only about 23% incur liability from the use of hospital services.

III. The Impact of Assignment

- Given the magnitude and unpredictability of beneficiary liability stemming from unassigned claims, the physician's decision to accept or reject Medicare assignment can be critical to the patient.

- Under Medicare's "participating physician" arrangement, 28.4% of physicians treating Medicare patients in 1986 agreed to accept assignment for all Medicare claims, a drop of two percentage points over 1985. There is, moreover, great disparity from state to state in the percentage of participating physicians from a low of 8% in South Dakota to a high of 54% in Alabama (1986).

  A similar disparity in participation rates exists across specialties, with a low of 22% for anesthesiologists to a high of 46% for nephrologists.

- The 1985 assignment rate was 68.5%, up dramatically from the 1984 rate of 59%. This improvement in assignment rates is attributable in large part to the implementation of the participating physician program in 1984. Moreover, gains seen in assignment rates in 1985 seem to have held in 1986, when assigned claims made up 68% of the total.

  (It should be noted that the current assignment rate for non-participating physicians is about 44%).

Medicare Part B Assignment Rates
1968-86

Year	Percent of Claims Assigned
1968	59.0
1970	60.8
1972	54.9
1974	51.9
1976	50.5
1978	50.6
1980	51.5
1982	53.0
1984	59.0
1985	68.5
1986	68.0

Source: HCFA

- Still, there remains significant variability in assignment rates across states. In 1986, 92% of claims submitted in Massachusetts were assigned, while only 35% were assigned in South Dakota. Assignment rates for specialties vary, as well, but HCFA has not updated these since 1982.

- Most physician charges submitted to Medicare are reduced prior to reimbursement. Between 1971 and 1985, the percent reduction on physician charges increased from 11.4% to 26.9%. The beneficiary bears the full financial burden of such reductions on all unassigned claims.

- The recent increase in unassigned claim liability during a period characterized by high assignment rates suggests possible increases in volume, the use of more expensive physician services, the influence of the two percentage-point decline in the physician "participation" rate, or a combination of these three.

IV. The Role of Medigap

- Most Medicare supplemental (Medigap) policies marketed since the enactment of the Baucus Amendment in 1980 are required to cover Medicare Part B coinsurance subject to a maximum plan deductible of $200 per year; they must also carry a maximum Part B benefit of not less than $5000. Relatively few Medigap plans cover even a portion of unassigned claim liability, and the cost of such coverage is usually prohibitive.

- About 70% of elderly Medicare beneficiaries purchase Medigap insurance plans. About 90% of these individuals are covered for inpatient physician care, and about 62% are covered for physician office visits.
- The cost of Medigap insurance ranges from about $200 to $1,200 per year, depending on the breadth and depth of coverage.

V. Elderly Out-of-Pocket Expenditures for Physician Services

Elderly out-of-pocket expenditures for physician services (including payments for non-Medicare covered services) are large and rising. Between 1977 and 1984, such expenditures increased by 195%.

	1977	1984	Percent Increase
	Billions		
Out-of-Pocket:	$2.2	$6.5	195%
Private Insurance:	$1.2	$3.4	183%

Revised February, 1987.

Mr. STARK. Thank you, Jack. Maybe you can help. You just heard Dr. Todd from the AMA testify that we should let the physicians set the fees, and the physicians will take care of worrying about volume. We should not worry about the volume. And we should let the doctors earn as much as they can. Now with that kind of help, our job becomes somewhat more difficult.

How would you suggest that we hold the costs of part B to inflation? And if in fact, and I guess everybody agrees, that the bulk of the part B payments go to doctors. So if we cut part B expenditures we are going to cut the money we pay to doctors.

There was one brief suggestion today that we look at an area and if there is too many of one procedure, we just cut the price per procedure. Many of your members belong to capitated plans, HMOs, some have been good, some have been bad. The State of Wisconsin recently made all Medicaid beneficiaries join HMOs. They have had some problems doing that.

What kinds of suggestions can you bring to the committee that we could entertain to hold down these costs?

Mr. GUILDROY. Mr. Chairman, I think all of us are looking for a quick fix, to put it very bluntly. It is very, very difficult. We have made two modest suggestions for improving the situation through short term savings by cutting down on the cost of so-called overpriced services. The AARP agrees with those eight procedures identified by the Physician Payment Review Commission.

We have also—we know that Congress last year encouraged the participating physician program. Maybe there are ways in which we can give further encouragement to the participation program.

I have said in our testimony, I have pointed out the importance of having up to date information through the participating physician directory. I regret to say that the physician directory, at least in my region, seems to be full of errors. That is no way to do the thing properly. And I am told that this probably is not an aberration, and I am horrified at the thought that it is not an aberration.

These are small, modest steps. There is no—we cannot see at least, any real solution to this in the short run. I am sorry, but this is the situation as—it is frustrating. It is frustrating to you who set policy. It is frustrating certainly to beneficiaries. And I am sure it is frustrating to physicians as well.

Mr. STARK. What would be your reaction, or what do you think would be your reaction if we just set national fees? The variance from one part of the country to the other is great.

Mr. GUILDROY. AARP does believe in a kind of a fee schedule, resource based, not charged based. We also believe it is necessary to make some adjustments for what is loosely called the cost of practice.

In other words, the charge for a—or the reasonable fee for a hip replacement in Port Washington, N.Y. probably should not be the same as it should be in Washington, District of Columbia or Selma, Ala.

Mr. STARK. Let us discuss that for a minute. Let us leave aside for a moment the modest differences in rent and overhead. Let us presume for a moment that hip replacement is a procedure that takes place in a hospital. There is no reason, I do not suppose, for an anesthesiologist to have a medical office outside of a hospital. Maybe there is, but it escapes me if there is.

So anesthesiology is a professional service. It is like an hour of a lawyer's time. There may be some related bookkeeping differences and so forth, but why should that fee be twice as high in Philadelphia as it is in Rochester, N.Y.? And there are instances—I am just picking those at random, but there are instances where this happens. Now is there any reason on God's green earth that we should have those fee variances?

Mr. GUILDROY. Mr. Chairman, I think the example or the analogy you just drew perhaps would be part of my answer to your question, which is a very good one. The cost for my attorney, for our attorney in South China, Maine is quite different from the cost for our other attorney in Port Washington, NY. Attorneys' fees do vary, and I am sure there is some justification for it, because they have differences in their practice costs.

But I think basically there should be a relative value scale based upon the various resources that contribute toward the procedures and the work, all of the effort that is used. And if that gets into place, that I think will go a long ways toward cleaning up the difficulties in the present UCR system.

Mr. STARK. Well, I do not know. Canada has a national—provincial rates. I submit that I can understand the difference in the cost of living in more rural areas than urban areas, and I suppose that is taken into account. But adjusting for that, I think we can give you some examples of urban centers of equally highly regarded medical centers, for instance, where the cost of a heart operation may differ by $2,000, $3,000, or $4,000; the same procedure, and the same highly trained, highly skilled, board certified surgeons in highly endorsed surgery centers, hospitals, and teaching hospitals.

Explain to me why the difference should be $2,000 and $3,000.

Mr. GUILDROY. I cannot explain it to you, obviously.

Mr. STARK. Or why we should pay it.

Mr. GUILDROY. I cannot explain it to you. On the other hand, I do want to point out that in the opinion of AARP—and I think you alluded to this yourself earlier—there are probably some physicians and some services that are underpaid at this time, which you referred to as cognitive services.

Mr. STARK. Absolutely.

Mr. GUILDROY. And it may sound—it may be difficult to talk about increasing reasonable charges, reasonable fees for certain physicians at a time when all of us are talking—when certainly the Congress is talking about cutting back. But this must be said, it seems to me, in all good conscience. There are some services and, consequently, some physicians who are underpaid.

Mr. STARK. I agree wholeheartedly. And you have heard the testimony here today—of getting much assistance out of the physicians. And that is the dilemma we are in. That will lead us, in the next year or two to do something rather severe in limiting the payment.

We have no one but ourselves to negotiate with, and we are going to be under some real pressures, if not from your members on the part B premiums, then from the budget constraints that either Gramm-Rudman or the administration will put on us. And my principal concern is the seniors, our beneficiaries, many of whom are your members.

Mr. GUILDROY. We have been hearing——

Mr. STARK. What I am looking for is that method. There are implied threats from the physicians that they will not provide the service. I always figure that you stand up to a bully and challenge them or they will threaten you for the rest of your life. So I tend to ignore those implied threats by the AMA that if we do not pay the doctors enough they will strike, or walk off, or the quality of service will drop.

We have criminal laws that deal with the withholding of services and the quality of services, and I will turn those doctors over to the Justice Department or the proper district attorney.

In the sense of what would be less inconvenient or less disruptive for your members, I think that is what we need, because I do not think we have the luxury or the time to wait. I mean, the testimony was that the reason these prices go up 10 or 12 percent a year is because that is what they have been doing all along. That is the problem. I mean, the AMA accepts 10 or 12 percent or whatever the figures they have as that being nature's natural course.

The fact is, it is those increases that have caused the increase in your part B premium.

Mr. GUILDROY. I wonder if you would permit me to comment on something that I heard.

Mr. STARK. Sure.

Mr. GUILDROY. I heard great support for capitation, HMOs.

Mr. STARK. By Dr. Roper.

Mr. GUILDROY. By Dr. Roper. And one of the highlights, it seems to me of his position, one of the main reasons for support was that you would get decisions made at the local level and not here in the District of Columbia. It strikes me that under the present system of operation many decisions, perhaps most decisions on Medicare, theoretically a national program, are also made at the local level.

Mr. STARK. I think you are right.

Mr. GUILDROY. That it is the carriers at the local levels, State or local level which have a lot of discretion about decisions that are made. That there are relatively few mandates from HCFA about what they can do and what they cannot do.

Mr. STARK. Do you mean intermediaries?

Mr. GUILDROY. Yes, talking about intermediaries or so-called——

Mr. STARK. My guess is that they do not do much. I mean, they process the paper and they look for mistakes, but they merely react to the reasonable and necessary or historic system that is already in place in the community they serve.

Mr. GUILDROY. Congressman, we have some evidence—it is anecdotal for the most part, that these so-called carriers are turning beneficiaries down, and physicians also so far as payment is concerned. They are reducing payment.

Mr. STARK. That is in response, I suspect, Jack, to Medicare—to HCFA's pressuring of——

Mr. GUILDROY. No, what I am saying is that HCFA is giving the carriers, it seems to me—it seems to us— quite a good deal of discretion that is turning, that has turned or has succeeded in preventing a really national program from existing.

Mr. **Stark**. Possibly. As I say, I do not mean to discredit the intermediaries but I think that their function is more that of processing claims, and much more clerical in nature than——

Mr. **Guildroy**. We wish we could agree with you completely, Congressman.

Mr. **Stark**. Well, I wish you could come up with the answer, Jack, because it is ultimately your members that are the highest priority and our concern. And the second group are the taxpayers. And if we get either one of those groups bent too far out of shape, we will have some kind of a revolt.

The recipients of all this largess are being noticeably quiet and just willing to have that munificence rained down on their head. But I think that has to stop. And your continued help and input will be appreciated, as it has in the past. And I am sure this committee is going to have to deliberate next year on what we do.

And I hope that the AARP and other groups will at least come to us with a set of priorities, because I am sure the one solution you do not want is to just let that premium go up at the rate it has been going up.

Mr. **Guildroy**. That is correct.

Mr. **Stark**. Now I have got to charge you with coming back and helping us solve the problem, and I know you will.

Mr. **Guildroy**. Thank you, Mr. Chairman.

Mr. **Stark**. Thank you very much for being with us today. With that, having saved the best until last, Jack, the meeting is adjourned.

[Whereupon, at 3:58 p.m., the hearing was concluded.]

[Submissions for the record follow:]

STATEMENT OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

Recently, the Reagan Administration released figures that project that the premiums patients must pay for Medicare Part B coverage (the supplemental part of Medicare that covers physicians' services; services of certain non-physician health care professionals; medical devices; and clinical laboratory services) will increase on January 1, 1988 to $24.80 per month, a 39 percent jump over 1986 premiums. The increase has been largely attributed to a 20 percent increase in Medicare expenditures for services covered under Medicare Part B, although--as discussed later--this is but one part of the explanation for the rise in the premiums.

This announcement has generated understandable concern among beneficiaries, physicians, government officials and members of Congress. The American Society of Internal Medicine (ASIM), which represents those physician specialists in adult medical care that treat 43 percent of the Medicare population, strongly shares those concerns. Our members are acutely aware that the premium increase--about $85 per year--will impose hardship on many of their financially-disadvantaged patients--and in the worst cases could result in some patients dropping their Medicare coverage. This is a result that everyone must (or should) be committed to preventing.

But we are also very concerned that some people--including people in influential positions who should know better--are reacting in an ill-advised, rash and kneejerk manner, by placing all of the blame on physicians and calling for "tight limits on physician fees." That may be the politically popular thing to say. But unfortunately, it is the wrong answer to the problem--wrong because it misrepresents the facts, wrong because it will not work (most physician fees actually were frozen and thus could not have anything to do with the current cost or premium increases), and wrong because it is unfair. And it is wrong because it creates an atmosphere of confrontation and polarization, rather than an environment where we can all work together to develop constructive approaches to the problems facing Medicare patients.

A good place to begin is by putting aside "finger-pointing" and "blame-placing" and instead look at what we know--and of equal significance, don't know--about what's going on. *A look at the facts suggests that a variety of factors have had some role in the premium increase, including the government's decision to keep premiums artifically low in prior years; new laws enacted by Congress that increased costs (including expansion of benefits for services of non-physicians); a desirable and intended shift of services out of expensive hospitals into less costly physician offices; an increase in the over-65 population and, in particular, those over 85 (who generally require more services); continued improvements in patient care; and greater access to physician services because of the growing supply of physicians. It is equally clear, however, that much is still not known about how much each of these (and other factors yet to be identified) may have contributed to the premium rise.*

On September 15, Glenn Hackbarth, Deputy Administrator for the Health Care Financing Administration (HCFA)--the agency that administers Medicare provided ASIM with the facts. Here is what we learned.

FACT: The estimated 1988 Part B premium increase is almost double the increase in Medicare spending--39 percent compared to 20 percent. This means that although increased program costs in 1987 are--and should be--a matter of concern, they explain only half of the premium increase.

FACT: The "prime reason" that the premiums are rising in 1988 at twice the rate of government spending for the program, according to Mr. Hackbarth, is that the government for the prior two years artificially kept premiums below what they should have been to provide adequate revenue for the program. In 1986, premiums did not increase at all; in 1987, they should have been set at $2.86 per month higher than they are today. By dipping into reserves rather than raising the premiums, the government has run out of money. Now, the bill has come due--meaning that beneficiaries are being hit all at once for a large premium increase rather than having smaller increases spread out over three years. Is it any wonder that the increase is "unprecedented?"

FACT: Medicare spending for the twelve months ending June 30, 1987 apparently has increased by 20 percent over the prior twelve months (July 1, 1985-June 30, 1986), but the government itself knows little about why this has occurred. But what we do know is that physician fees--what physicians are charging their Medicare patients--have virtually nothing to do with the increase. Here is the best information available at this time, based on what Mr. Hackbarth himself acknowledges is a "crude analysis" of the 20 percent increase (apparently, we won't really know for sure what is going on for another nine to twelve months.)

2% of the increase is due to MORE MEDICARE BENEFICIARIES than the prior twelve months, the result of an aging population. Obviously, nothing can be done about this part of the cost increases.

+ 2% is due to a new law passed by Congress that requires PROMPT PAYMENT of Medicare claims. Congress passed this law because patients were waiting as long as six weeks to get reimbursed by the program—something everyone agreed was unacceptable. The result is that Medicare paid more claims in 1986-87 rather than delaying and paying them in the following year as they had done in the past. Again, nothing could be done about this portion of the increase, unless Congress just ignored the problem of slow payment.

+ 7% of the increase is due to Congress' decision to UPDATE MEDICARE PAYMENTS to patients, physicians, suppliers, laboratories and other non-physician providers (the so-called Medicare "allowable charge")--the first increase in payments in almost four years for most physician services since Congress, in 1984, froze payments for most physician services until 1987 at July 1, 1983 levels.

Subtotal: 11% which represents the amount of the cost increase due to demographic changes (aging population) and laws Congress itself enacted to correct problems in the Medicare program. (It is unfortunate that some members of Congress are now blaming physicians for the cost of laws they themselves enacted).

+ 9% represents MORE SERVICES provided to Medicare patients (the so-called "utilization," "volume" or "intensity" increases). This factor--which represents less than half of the overall cost increase--is the only one that can be directly attributable to physicians, at least in part, since they order many (but not all) medical services for their patients. But "more services" does not necessarily mean "unnecessary services," as discussed below.

Total 20% total increase, July 1, 1986 through June 30, 1987.

FACT: The 7 percent portion of the increase in Medicare payments (discussed above) for Part B covered services has absolutely nothing to do with charges or fees (how much physicians charge for their services), except for the neglible impact of the minority of physicians who agreed to accept Medicare's "approved amount" for all services (participating physicians) and thus were exempted by Congress from the fee freeze. The fees of all other physicians were frozen by law from July 1, 1984 through December 31, 1986, and remain under tight controls that limit most fee increases to one percent (and in some cases require reductions in fees). It is disingenous, to say the least, for members of Congress to now call for "tight new limits on fees" when they know that fees have been subject for most of the past three years to the toughest limits of all--an outright freeze—and therefore have nothing to do with the recent premium or cost increases.

FACT: Comparing cost increases for the twelve months ending June 30, 1987 with the prior twelve months ending June 30, 1986, is misleading for several important reasons:

- Congress passed several laws in 1986 that they knew would increase costs in 1987; including the prompt payment provisions and the updates in Medicare payments (discussed above). They also added new benefits for non-physician services--physicians' assistants and optometrists—that have some impact (amount unknown) on the increased costs. The costs of these new benefits specifically would be included in the 7 percent increase in Medicare payments and the 9 percent increase in services. On January 1, 1987, Congress also authorized Medicare to pay 100 percent of the allowable for all lab tests, instead of the prior 80 percent for tests if physicians or labs did not accept assignment for services—which also would contribute to spending increases.

- Almost all of the congressionally-mandated increases in Medicare payments were associated with the twelve months ending June 30, 1987, not during the prior twelve months. In the twelve months ending June 30, 1986, only one increase in payments for physicians' services took place, and that was a 4.1 percent increase in payments to participating physicians' (those who agreed to accept Medicare payments in full) on May 1, 1986—meaning that those increased costs were included only in the last two months (May-June, 1986) of that twelve month period. By comparison, the 4.1 percent increase for participating physicians was in effect for the entire twelve months ending June 30, 1987, and the additional 3.2 percent increase on January 1, 1987 for all physician services was included in the costs for fully half of that latter twelve month period (January-June, 1987). Therefore it is not at all surprising that there were substantially increased costs from one year to the other.

FACT: Much of the 9 percent increase in services provided to beneficiaries has been attributed by the government to Medicare's new way of paying hospitals, which encourages the treatment of patients in the less expensive physician office setting—something everyone agrees is desirable. Treating patients in a less expensive (and more convenient) setting actually saves Medicare money overall, since it reduces the high costs of hospitalization. It may also save patients money, by providing an alternative to hospitalization, thereby saving the patient Medicare's $492 hospital deductible (paid out-of-pocket by the patient before Medicare will pay anything).

FACT: Of the remaining increase in services to Medicare patients, no one knows how much of this represents improvements in patient care, services being sought by patients, and services that could appropriately be reduced without hurting patient care. Certainly some—and quite possibly most—of it represents better service: the availability of new and better technology and improved access to physician services. The increase in the numbers of physicians, "defensive medicine" resulting from the medical liability crisis, and an increase in patients over the age of 85 (who usually require more services) may also be part of the reason more services are being provided. The challenge for physicians, the Administration, Congress and others is to find ways to cut out "wasteful" and unnecessary services without eliminating needed services or stifling advancement and innovation. That challenge is not one that can be met by a "quick fix."

FACT: If nothing else, all of the above proves that new limits on Medicare payments and physician fees will not work. Congress tried this and failed: costs continued to increase during the three years that payments and fees were frozen. The same thing happened throughout the economy during the wage and price controls of the early 1970s. Several studies suggest, in fact, that price controls actually increase costs. It is ironic that some members of Congress still believe fee controls are an easy answer to Medicare's cost problem.

Summary and Conclusion:

In summary, a few final conclusions can be offered about the recently announced premium and cost increases:

1. We know relatively little about why they occurred.
2. Almost 80 percent of the Part B premium increase appears to be due to factors not directly under physician control, such as the premium "catch up," demographics, and laws enacted by Congress.
3. The one factor over which physicians do have considerable influence—the growth in services to beneficiaries—requires much more thought and discussion over how best to limit waste without endangering access to needed services.

ASIM, for its part, is committed to ensuring access to needed services. If unnecessary care is being provided, we stand willing to assist in identifying ways to eliminate misuse and overuse. We also are committed to other changes to make medical care more cost-effective. That is why we support major reforms in the physician payment system that will help reduce costs by shifting incentives away from high cost technology toward cost-effective primary care and cognitive services. That is why we have advocated innovative approaches to Medicare financing that will relieve the premium burden on beneficiaries, by putting Medicare on a fiscally sound basis and obtaining revenue from sources other than the beneficiaries themselves. And that is why we have pledged to work with the Physician Payment Review Commission to develop constructive approaches to slowing inappropriate increases in the volume of services.

But we strongly urge Congress, the Administration and others not to engage in "quick fixes" or "finger-pointing." The stakes are simply too great to allow that to happen.

STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT

CHAIRMAN OF THE NATIONAL COMMITTEE

TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four and a half million members. The vast majority of our members depend on Medicare for their primary health insurance protection.

I want to commend the Chairman and the Committee for holding this hearing. Your expedient response to the Administration's announcement of drastic increases in the Medicare B premium shows your deep concern and willingness to act to protect seniors against this serious threat.

Unquestionably, a 38.5 percent increase in monthly premiums would have a major impact on seniors' out-of-pocket medical outlays. The premium has already doubled from $8.70 in 1980 to the current $17.90 a month. A new monthly premium of $24.80 would cost beneficiaries almost $85 more a year. Should the catastrophic coverage legislation become law, seniors could be asked to pay close to $345 in Part B premiums and a new supplemental premium next year - a minimum $130 increase in just one year. This is one week's income for the average Social Security beneficiary. Indeed, this constitutes a serious threat to the majority of older Americans, especially considering that the Social Security cost-of-living adjustment is only expected to be 4 percent next year.

One of our members recently wrote to ask our advice as to whether she should drop her Medicare Part B coverage because the $17.90 a month premium took a big bite out of her meager income. Thank goodness she asked someone before taking such serious action. In spite of the many flaws, Medicare still provides important coverage. But how many people will simply drop Part B because they can no longer afford the premiums if the monthly premium reaches $24.80, or close to $30 with catastrophic coverage? It is a frightening thought.

Mr. Chairman, clearly Congress must attack this onerous trend by putting a stop to unchecked premium increases. We ask you not only to roll back the scheduled increase in January, but also see to it that the law requiring premium increases to be limited to the percentage of the Social Security cost-of-living increase beginning in January 1989 remains unchanged. This action must be taken to safeguard seniors' limited income against medical inflation and has been a part of the National Committee's agenda since its inception. Congressman Pepper has already introduced legislation, H.R. 3291, which we support, to limit premium increases to the COLA in 1988.

The record shows that Congress generally exercises good judgment when crises arise. Last year, Congress curbed increases in the Medicare Part A deductible when it became evident that increases were rising many times faster than cost-of-living adjustments as a result of the new hospital cost containment program. Congress realized that it was unfair to ask seniors to pay for hospital cost containment. You and your colleagues took the necessary steps to prevent further erosion of seniors' retirement incomes.

Certainly, the increases in Medicare Part B premiums have not come as a complete surprise to this Committee or to anyone in the health care community. Spending on the Medicare Part B program has increased at an annual rate of 17 percent over the last ten years. One reason for this continuing rise is physician costs. Let us not be fooled by the American Medical Association and individual physicians who bitterly complain about their fees from Medicare. Physicians have managed to maintain average annual earnings of over $113,000 despite the Medicare fee freeze in 1985 and other fee constraints. Inflation in physician services as measured by the medical economic index continues to rise at a higher rate than the consumer price index.

Another reason for the large premium increase is the shift from Part A to Part B services. Nothing short of a revolution in health care took place when the DRG system was implemented with the Social Security Amendments in 1983 to contain hospital costs. Hospital stays are shorter. Fewer and fewer procedures are deemed necessary of requiring hospitalization. With the growing demand for out-patient services, new facilities, expanded facilities, remodeled facilities have sprung up everywhere. Services previously provided under Medicare Part A are now being provided under Part B in out-patient centers. Every one of these centers strives to be equipped with current and specialized equipment. The bottom line is that consumers pay the price. The premium increase is simply another piece of evidence that beneficiaries rather than hospitals are suffering the brunt of the fall-out from the DRG revolution. What was sold to the public as a measure of cutting the fat from medical institutions in reality is scraping the bones of seniors' income.

The current fee-for-service concept of medical care reimbursement begs for abuse of the Supplementary Medical Insurance program by unscrupulous doctors. The more times a patient is asked to come back to see the physician, the more tests and services furnished, the more enriched the provider becomes. The Health Care Financing Administration data substantiates that both the volume and the average charge for each service continue to grow. And it is estimated that physicians' decisions about ordering further patient treatment directly influence over 70 percent of all health care spending. This system must be changed -- but changed in a manner which does not endanger quality of care.

We hope that Congress will use this increase as a springboard for real reform of the physician payment system. But while planning on reform, Congress should protect Medicare beneficiaries from this unfair 38.5 percent increase in Medicare Part B premiums. We urge you to curb this unprecedented increase and limit it to no more than the COLA.

Congressman Harold L. Volkmer
House Committee on Ways and Means
Hearing on Medicare, Part B Premium Increase for 1988
September 30, 1987

CAP SOARING MEDICARE, PART B PREMIUMS

Mr. Chairman I am very pleased that you responded as quickly as you did to the announcement that the Health Care Financing Administration was proposing that Medicare, Part B Premiums be raised from $17.90 to $24.80 beginning January 1, 1988.

I think every senior citizen's heart skipped a beat the moment they read about this 38% increase in their annual premium and that the annual premium of $214.80 would go up by $82.80 to a total of 297.60.

For some people this may appear a small amount but it must be coupled with the increase which will occur when the Catastrophic Illness Protection Act is finally passed and signed into law by the President.

Because of this, I urge you to continue these hearings with the intention of developing legislation which will control the causes of this increase and limit, in the future, the amount a Medicare Part B Premium can increase in any given month. From my perspective this may require a cap on the monthly premium. Such a proposal will require reforming the Medicare payment system but, if we are to prevent this from happening again, Congress must act now.

I commend you for taking the leadership on this issue and look forward to supporting a proposal to reign in the rising cost of the Medicare, Part B program.

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